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The Journal of Cutaneous Diseases

INCLUDING SYPHILIS

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THE JOURNAL OF CUTANEOUS DISEASES
INCLUDING SYPHILIS

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CONTENTS.

ORIGINAL COMMUNICATIONS.

Idiopathic Multiple Hæmorrhagic Sarcoma (Kaposi) M. B. Hartzell, M.D..... 97
The Clinical Groupings of Tropical Ulcers of the Philippines, with some Negative Notes as to Etiology and Treatment. Surgeon E. R. Stitt, U. S. Navy..... 103
Observations on Skin Diseases in the Negro (concluded) Howard Fox, MD..... 109
Some Experimental Observations on the Histo-pathology of Urticaria Factitia. T. Caspar Gilchrist 122
The Effects of Roentgen Rays on Paget's Disease of the Breast. Dr. Roberto Terzaghi and Prof. Campana 123

SOCIETY TRANSACTIONS.

New York Dermatological Society (December)..... 125
Ichthyosis hystrix.—Case for diagnosis.—Pemphigus vegetans (?).—Erythema multiforme (Perstans).—An unusual case of lupus erythematosus with cutaneous infiltrations resembling circumscribed scleroderma.—Erythematous eczema.—Tuberculosis of right hand (?).—Adenoma sebaceum of chest and back.—Unilateral sweating.—Necrotizing chilblains (*prev. shown*)
Section of Dermatology, N. Y. Academy of Medicine (October)..... 133
Xanthoma tuberosum multiplex.—Method of making liquid carbon dioxide for dermatological and surgical use.
Chicago Dermatological Society (November)..... 138
Congenital syphilis.—Lupus erythematosus, unusual case.—Blastomycosis.—Psoriasis.—Ichthyosis.—Universal psoriasis.—Case for diagnosis.—Case of disseminated chronic lupus erythematosus in large patches.

REVIEW OF DERMATOLOGY AND SYPHILIS.

Bacteriology and Parasitology .....
Sporotrichosis, a digest by A. D. Mewborn..... 140
Authors quoted.—Schenk, Brayton, Hectoen and Perkins, DeBeurmann and Ramond, Matruchot and Ramond, DeBeurmann and Gougerot, Dor, Monier-Vinard, Gaucher, Rubens-Duval and Fagé, Lauby and Esmein, Demoulin and Rubens-Duval.

BOOK REVIEWS.

Syphilis in its Medical, Medico-Legal and Sociological Aspects. A. Ravogli, M.D..... 144
Jahresbericht ueber die Leistungen und Fortschritte auf dem Gebiete der Erkrankungen des Urogenital Apparates. Drs. Kollmann and Jacoby..... 146
Atlas der Venerischen Affectionen der Portio Vaginalis Uteri und der Vagina. Dr. M. Oppenheim 146
Diseases of the Genito-Urinary Organs and the Kidney. Robert H. Green. Harlow Brooks..... 147

OBITUARIES.

In Memoriam, Robert William Taylor..... 148
Professor Oscar Lassar 150

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXVI. MARCH, 1908. No. 3

IDIOPATHIC MULTIPLE HÆMORRHAGIC SARCOMA (KAPOSI)

By M. B. HARTZELL, M. D.

Associate in Dermatology, University of Pennsylvania; Clinical Professor of Dermatology, Woman's Medical College of Pennsylvania; Dermatologist to the Philadelphia Hospital.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

IN 1872 Kaposi [1] first called attention to an unusual and remarkable affection of the skin characterized by the occurrence of deeply pigmented infiltrated patches and small tumors, situated almost invariably on the extremities, followed after several years by visceral metastases and death, for which he proposed the name "idiopathic multiple pigmented sarcoma," a name which he, twenty years later, changed to idiopathic multiple hæmorrhagic sarcoma, as being more accurately descriptive of the disease. At the time of this first communication he had seen but five cases, but this number had increased to twenty-five up to the time of the publication of the last edition of his well-known treatise on diseases of the skin. He regarded the malady as a typical, although special and peculiar, form of round-celled sarcoma, with the occasional occurrence of characteristic spindle cells. Soon after the appearance of Kaposi's paper other observers began to report similar cases, and the list has steadily though slowly grown, until the number of recorded cases is now something over 100. Although the affection is a relatively rare one, most of those who have written about it having seen but a small number of cases, yet one observer, De Amicis,[2] reports having seen more than fifty, by far the largest number observed by any single individual. While the affection seems to be peculiar to no country or race, the great majority of the cases on record have been reported by European observers, and fully one-half of these from the northern provinces of Italy. The number of cases reported in America is extremely small, and some of these oc-

[1] *Archiv f. Dermatologie u. Syphilis,* 1872.

[2] *Monatshefte f. Prakt. Dermatologie,* Bd. xxv.

curred in foreign-born. For this reason, among others, I have thought it might be worth while to add a new and typical case of this very remarkable disease to the list of cases occuring in native-born Americans.

S. M., sixty-nine years old, a traveling salesman by occupation, in excellent general health, came under my observation in January of this year, seeking advice for an affection of the legs which presented the following features: On the dorsum of the left foot and the anterior surface of the leg were numerous round, oval, and irregularly-shaped, slightly elevated, or on a level with the healthy skin, very dark-brown and slate-colored, for the most part smooth, but in places slightly scaly, firm patches. On the calf the disease consisted of many pea- to hazel-nut-sized, confluent firm nodules similar in color to the patches on the anterior surface of the leg, forming a large uneven patch covering the entire calf. Here and there were a few coin-sized, depressed, scaly, less-deeply pigmented areas which, according to the statement of the patient, represented patches of nodules which had undergone partial involution. Over the outer malleolus was a single nut-sized, pedunculated tumor, projecting considerably above the surface, which gave the patient much annoyance because of the pressure exerted on it by the shoe, and the frequent injury which it suffered, owing to its exposed situation, by being caught by the clothing and the bedclothing, considerable hæmorrhage taking place from it at times. Upon the right leg the disease was much less extensive, the lesions being comparatively small in number, smooth, flat, without any tendency to the formation of tumors. The left leg was several inches larger in circumference than the right one, was very firm to the touch, but did not pit on pressure. There was marked itching and some burning, but never positive pain, although walking was somewhat interfered with by the swelling of the left leg and stiffness of the skin about the ankles. The disease had begun fourteen years previously, with intense itching at the root of the toes and smooth pigmentation of the dorsum of the foot, and had remained limited to the left extremity until two years ago, when it began to appear on the right foot and leg. The numerous tumors on the left calf were first noticed some five or six years ago. With the exception of a single thumbnail-sized patch on the inner surface of the left thigh, the disease was strictly limited to the legs and feet.

The treatment employed consisted in the local use of antipruritic lotions for the relief of the severe itching which gave the patient much trouble at times, the internal administration of arsenic in fairly large doses by the mouth, and the use of the X-ray. Up to the present time some fifty X-ray exposures have been made, chiefly to the left leg, at intervals of three to five days, each exposure lasting from

seven to ten minutes. Owing to a severe and prolonged attack of thoracic zoster, which was probably arsenical in origin, the treatment was suspended for four or five weeks, and has been carried out somewhat irregularly since. The large nodular patch on the left calf was the first to be subjected to X-ray treatment, and showed decided improvement after twenty-five exposures, the small tumors becoming less prominent and losing pigment; and a similar improvement has been observed in all the parts subjected to this treatment. The itching which was the chief subjective symptom, almost entirely disappeared so that the patient no longer found it necessary to use the lotion which had been given him for the relief of this most annoying symptom. At an examination made within a day or two, striking improvement was found; not only was there a decided diminution in the size of the tumors and a noticeable decrease in the amount of the pigment, but the swelling of the left leg had diminished to such a degree that it was but very little larger than the right one. It is perhaps worthy of note that, notwithstanding the number of X-ray exposures, there has never been the slightest evidence of dermatitis. May this immunity be due to a protective action exerted by the deep pigmentation of the skin?

Because of its exposed position and consequent frequent injury the tumor over the left external malleolus was excised and subjected to microscopic examination. This examination showed that, apart from a moderate increase in the thickness of the corneous layer, the epidermis was normal. The papillary layer of the corium had entirely disappeared and the corium itself was almost entirely replaced by a cavernous tissue, which under a moderate magnification, resembled an angioma. It was composed of numerous large round and oval cavities, with thin walls filled with blood, with here and there small islets of round or spindle cells between, and in which was an abundance of golden-brown pigment granules. Under a sufficiently high power it could be seen that the blood-filled spaces were lined by endothelial cells, and that the round and spindle cells were contained in a rather coarse fibrous mesh-work. In most instances the spindle cell tracts surrounded capillaries, the long axis of the cells running parallel with the walls of the vessels. The pigment, which was present in great abundance, was situated both within the cells and between them, in the former case frequently obscuring more or less completely the outlines of the cells. The cell-elements of the tumor were in all probability entirely of the spindle-cell variety, the apparently round cells being most likely transverse sections of spindle-shaped cells. In addition to the blood in the cavities already described, there were numerous interstitial hæmorrhages visible in various parts of the tumor.

We are practically without any definite knowledge of the causes, predisposing or direct, of this very remarkable malady. Age seems to have little or no influence upon its occurrence, cases having been observed at all ages between 5 and 80, although the great majority occurred in adult life. Semenow,[3] who saw 10 cases in Stoukowenkoff's clinic within the comparativey short period of five years, noted that a large proportion of these had been exposed to more or less severe and prolonged cold, and was inclined to attribute a causative influence to this factor. In one of his cases the bluish nodules occasionally disappeared spontaneously, but always reappeared in damp and cold weather. Micro-organisms have been diligently searched for, but without success. It is true that Pringle[4] has reported the finding of bacilli in two cases, but other investigators have failed to confirm this finding. Bernhardt[5] believes the parasitic theory would best explain its origin, but his bacteriological investigations, like those of others, have been fruitless. This author reports a case in which frequent attacks of erysipelas occurred, but instead of exerting a favorable influence upon the course of the malady, as in some other forms of sarcoma, these were always followed by the appearance of fresh sarcoma nodules in the areas affected by the erysipelas.

The course of the disease is usually quite slow, extending over years, new lesions appearing at longer or shorter intervals and slowly enlarging. Exceptionally, however, lesions may appear very suddenly. Semenow has seen a large blue patch appear in the course of a single night. This sudden appearance of extensive new lesions is due, according to Bernhardt, to the occurrence of abundant, sharply circumscribed hæmorrhages into the skin which simulate sarcomatous nodules. The mucous membranes may be implicated comparatively early in the course of the affection, as evidenced by the appearance of pigmented patches on the buccal and palatal surfaces. Visceral metastases occur late and usually soon bring about a fatal termination. It is of interest and importance to note that the bones of the extremities may be involved in the morbid process. In one of Bernhardt's cases disease of the bones of the foot was demonstrated by the X-ray, and after amputation it was found that the phalanges, with some of the metatarsal and tarsal bones, were almost destroyed, being converted into a spongy mass. Halle like-

[3] *Monatshefte f. Prak. Dermatologie*, Bd. xxv.

[4] *Comptes Rendus Congrès International de Dermatologie et de Syphiligraphie*, Paris, 1890.

[5] *Archiv f. Dermatologie u. Syphilis*, Bd. lxii.

wise reports a case in which the bones of the great toe, enucleated on account of severe pain were found to be completely destroyed and converted into sarcomatous tissue. Although a fatal termination is to be expected when internal metastases take place, the patient's health is usually astonishingly well preserved until this time, the disease apparently exerting little or no influence upon the general economy so long as internal organs are not invaded. Spontaneous involution of some of the lesions, more or less complete, not infrequently takes place, as in the case I have reported in this paper. The small tumors become less prominent, grow paler, become scaly, and finally sink below the level of the surrounding skin. On the other hand, recurrences may follow extirpation of nodules.

Owing to the striking and peculiar symptoms of the disease, all observers are of one mind as to its clinical characteristics, but there is considerable divergence of opinion as to its histopathology, and more especially as to its place in nosology. While most authors agree with the view of Kaposi that the affection is a form of sarcoma, a not inconsiderable minority regard its sarcomatous nature as more or less doubtful, while a few deny it absolutely. Most of those who have studied its histopathology found the lesions composed of spindle-celled elements, either entirely or in large part; a few found only round or oval cells, while Kaposi and Perrin [6] found both types of cell. Bernhardt maintains that this form of sarcoma is exclusively spindle-celled.

De Amicis, whose experience with this malady has probably been larger than that of any other author, believes it a well-defined type of disease whose nosographic position lies between granuloma and real sarcoma and whose nature is unknown. On account of the severe pains which frequently accompany its early stages, the œdema, the severe itching, the increased activity of the secretory organs, the symmetrical distribution of the lesions, the collection of pigment which he found in the cells of the spinal ganglia, and finally because of some changes in the nerves themselves, Semenow believes that the affection is closely related to the nervous system in its origin. Bernhardt's investigations lead him to the conclusion that it is a sarcoma originating in the perithelium of the blood-vessels—a perithelioma—of unknown cause. Halle looks upon it as a disease of the vessel system and rejects the theory of its microbic origin; he believes it rather due to complicated processes taking place in the

[6] Thèse de Paris, 1886.

[7] *Monatshefte f. Prak. Dermatologie,* Bd. xxxi.

organism itself. Sellei[7] considers that recent histological investigations have shown that the affection is not a sarcoma—is not even to be reckoned among the new growths—but is a granuloma, and proposes to call it "*granuloma multiplex hæmorrhagicum.*" The study of my own case, and of the literature of the subject, leads me to agree with the views of those who regard the malady as a sarcoma of special type, and especially with the views of those who consider it a disease of the blood-vessels; certainly these play an important part in its production.

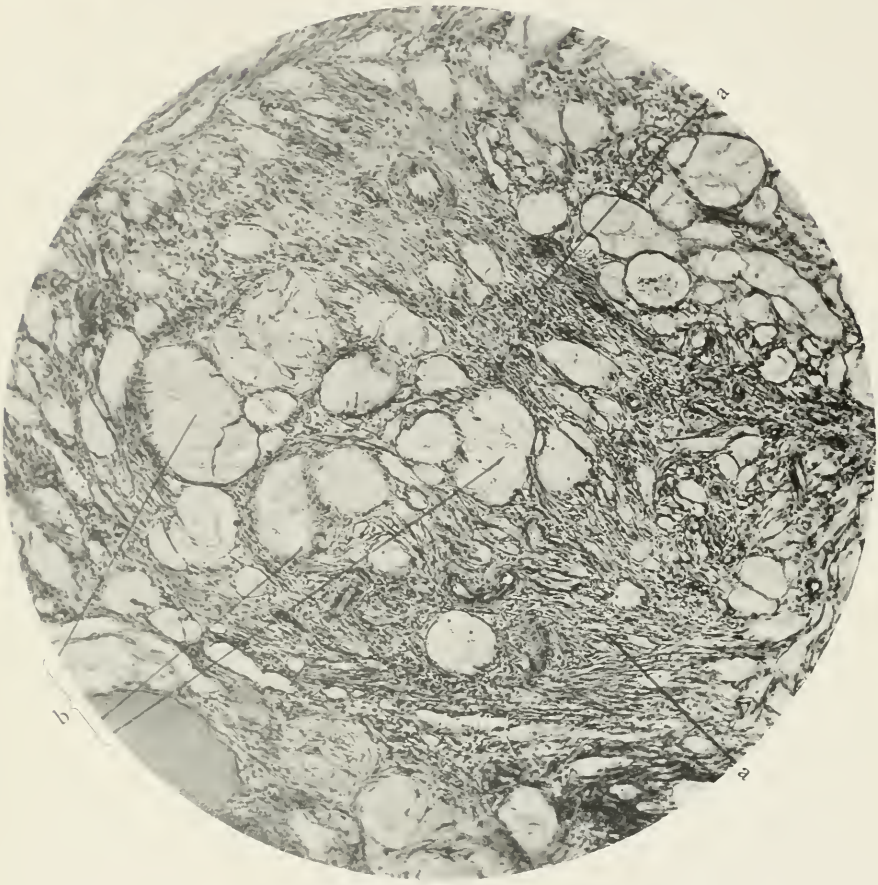
In view of the favorable reports of Köbner,[8] Sherwell,[9] and more recently of De Amicis, the use of arsenic is certainly to be advised in the treatment of this grave disorder. At the Congress at Rome, De Amicis reported 11 cases treated by subcutaneous injections of arsenic; in 5 of these there was no noteworthy benefit; in 2 there was essential improvement, and in 4 the course of the disease was arrested. Later he reported two additional cases; one, a boy 15 years old, in whom a cure was obtained after 100 injections; the other, a man 52 years of age, in whom almost complete recovery took place. On the other hand, Kaposi, Bernhardt, and others report nothing but complete failure in their trials with this drug. The chief difficulty in determining the value of any method of treatment in this affection lies in the fact that spontaneous involution of the lesions may take place, and, in rare cases, even complete recovery, as in the remarkable case reported some years ago by Hardaway.[10] Quite recently the X-ray has been employed with some benefit. Halle reports that, after producing a reaction of the first degree with this agent, there was a decrease in the infiltration and pigmentation; and Selhorst and Polano observed some improvement after the use of the ray. In my own case there was an undoubted diminution in the infiltration of the skin, and a decided lessening of the swelling of the limb, with decrease of pigment after prolonged X-ray treatment.

[8] *Berlin Klin. Wochenschift,* 1883.

[9] Jour. Cutaneous Dis., 1897.

[10] Jour. Cutaneous and Genito-Urinary Diseases, 1890.

PLATE XI.—To Illustrate Dr. M. B. Hartzell's Article.



Idiopathic Multiple Hæmorrhagic Sarcoma
16 mm. obj. Compens. Oc. 4.
a.—Spindle cell areas.
b.—Cavities containing blood.

The Journal of Cutaneous Diseases, March, 1908.

THE CLINICAL GROUPINGS OF TROPICAL ULCERS OF THE PHILIPPINES, WITH SOME NEGATIVE NOTES AS TO ETIOLOGY AND TREATMENT.

By Surgeon E. R. Stitt, U. S. Navy.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

DURING the first few months of my service in the Philippines the question of the nature of the various ulcerations so common among the natives interested me greatly.

The findings of Wright as to the presence of Leishman-Donovan-like bodies and the negative results regarding them obtained by Strong, together with his putting forward of a yeast-like organism as a possible causative factor, made the subject seem one that might offer great opportunities for investigation.

Keeping in mind the type of ulceration described under the various designations of Aleppo Evil, Delhi Sore and Bagdad Boil, I was constantly on the lookout for ulcerations which would clinically correspond with the descriptions of these diseases.

Of the many articles describing these sores the most concise and satisfactory ones are:

I. *As Regards a Division into Stages.*—Where in an article on Aleppo Evil, Cazenave and Schedel quote from M. Guilhou, who in 1835, described the condition in three stages: *First*—of eruption: a lenticular swelling which gradually increased during four or five months without general symptoms: *Second*—of suppuration: in which deep and irregular ulcers were a prominent feature during the succeeding three to five months: *Third*—a stage of dessication: in which dry tenacious scabbing occurred for the remainder of the year.

II. *From a Clinical Standpoint.*—The description of the late Sir Joseph Fayrer (*The Practitioner*, 1875, pp. 264), is a most excellent one. He describes it as an indurated indolent sore at first papular, later encrusted and fungating. The small red papule gradually enlarges during several weeks, then becoming an indurated sore.

He notes that inoculation was only successful by the introduction of the specific cell matter and not the exuding pus.

After observing in the natives a number of chronic ulcerations, especially of the lower extremities, and finding that clinically they did not differ from ulcerations which might be expected from badly infected and neglected wounds, or from the infective granulomata, and that from a standpoint of history there was the single common statement of long duration, I came to the conclusion that the form of tropical ulceration as described in the books did not exist in the Philippines—at any rate in the hospitals.

Subsequently, in Guam, I observed the same thing. Many cases of most extensive and frightful ulcerations of the extremities were noted, in none of which could one eliminate the possible cause of tuberculosis or infected yaws when those due to leprosy were set aside. It was impossible to obtain a history of a papular, comparatively painless swelling, lasting several weeks or months—in other words, there was nothing to connect such cases with oriental sore.

It is interesting to note that the Spanish of the island of Guam divided their quarantinable skin cases into three types:—1. The *gangosas*, when the ulceration was confined to oral and nasal cavities; 2. The *leprosos*, where in addition to face lesions there were the various leprotic lesions of the extremities. and 3. The *llagosos*, which would include those cases principally showing lesions of the lower extremities—possibly tuberculosis—possibly tropical ulcer.

That the confusion existing as to the clinical characteristics of oriental sore was due to mistaking cosmopolitan skin affections for the more geographically circumscribed oriental sore is clearly shown in a contribution by Dr. Gebers in the "*Archiv für Dermatologie und Syphilis*," 1874, where he takes issue with those calling all ulcerations about Aleppo, Aleppo Evil, when he, upon an examination of a series of so-called cases, found the greater proportion to be either syphilitic, tuberculous or eczematous. Anyone reading the classical descriptions on the subject of oriental sore in "Endemic Skin and other Diseases," Tilbury Fox, 1876, must be convinced that the descriptions by various observers certainly refer to a variety of skin lesions.

The confusion as to clinical course and characteristics which had existed in my mind from my earlier observations of these skin lesions was in a measure cleared up by the opportunity of observing several cases among Americans—most of these coming from sailors under treatment in the Naval Hospital, at Canacao, P. I.

These cases were of two distinct types—the one more nearly conforming to the description as given by Fayrer—the latter to

Jeanselme's description of tropical phagedena. As regards the first type: 1. A history of a red spot or lump coming generally on the outer surface of the lower extremities which had gradually enlarged as a painless swelling. While not subjectively painful and only slightly tender to pressure yet complaint was made of a stinging sensation of pain when the swelling was sharply struck. There is considerable itching at times and I am inclined to think that some of the scaling described as preceding ulceration may be secondary to scratching: 2. After slowly enlarging for from four to eight weeks this circumscribed reddened glazed area of skin, giving about the sensation of a solid œdema on palpation, begins to exude from its summit a serum which quickly dries and crusts. Just prior to this it would be mistaken by the average practitioner for a blind boil: 3. Ulceration now proceeds under this encrusted secretion more or less rapidly. There is only a scanty discharge of a serum-like, at times, sanious, secretion which tends to crust over. The ulcers are shallow with irregular, somewhat undermined edges. Later on the ulcers are more or less punched out and may show considerable induration. In some instances I am disposed to think that the induration was the result of frequent cauterization: 4. These remarkably painless chronic ulcers in a person whose health seems unimpaired continue for from three to six months, varying only as a result of the trial of some new form of treatment. In our most characteristic case where there were several of these ulcers the patient enjoyed robust health: 5. After from two or three months to a year these ulcerations show a tendency to heal under the crusts and eventually give rise to a pale, somewhat puckered, cicatrix with pigmented margins.

The shortest period in which the discharge showed itself—that is, in which ulceration set in—was 22 days. It is as a rule much longer.

These ulcerations when curetted failed to show any pyogenic organisms. The smears, as will be seen in the specimens exhibited, show practically an absence of polymorphonuclears, cells of the lymphocyte type predominating. There are many large cells, 20 to 30 μ in diameter, some of which look as if full of small circular bodies which, however, show no chromatin staining (Giemsa's method).

Now as to the second type of ulceration observed: These sores were observed in persons greatly debilitated. It is interesting to note that in one case the sore was attributed to the eating of mangoes, an idea which was advanced by some of the early Indian writers on this subject.

In the earliest stages these sores seem to resemble an area which has been excoriated and inoculated with vaccine virus, there being a rather dry, angry-looking spot of erythema. This within a few hours may be surrounded by a circle of vesicles beyond which is an encircling inflammatory areola. There is marked subjective pain with tenderness. The serum from the vesicles fails to show any bacteria and the cellular contents are made up almost entirely of polymorphonuclear leucocytes. Within a few hours to one or two days the area within the ring of vesicles is converted into a dark grey to black pultaceous diphtheroid membrance which when detached shows underlying fungating granulations covered with greenish yellow pus. This membrane, if stripped off tends to reform with great rapidity (24 to 48 hours), and in many respects resembles the membrane of diphtheria, except for its dark color.

These ulcerations extend with great rapidity and even when showing a tendency to heal may suddenly, from a point along the margin, proceed to form a new area of ulceration, extending somewhat as would a ringworm. When the original site of ulceration fails to heal during a period of several weeks, the edges become rather indurated but do not show the punched-out or undermined characteristics of the first type.

These cases last for months and are far more tantalizing than the former type of ulceration for the reason that from time to time they show a strong tendency to heal, the process clearing up almost entirely, when suddenly the former area of the ulceration is equalled or exceeded.

In the former type of ulceration there is rarely any tendency to healing so that a favorable prognosis is not given.

Smears made from the surface of the granulations underneath the diphtheroid membrane, a specimen of which is exhibited, show a profusion of polymorphonuclears with an abundance of a branching, irregularly staining organism which somewhat resembled diphtheria, but was larger and did not show parallelism or involution characteristics. There was a total absence of any cocci or other bacteria.

The organisms described by LeDantec as occurring in cases of tropical phagedena apparently were similar but of larger size. James, in referring to Naga sores, states that he found polymorphonuclears in great numbers, but does not record the finding of any bacillus. It will be remembered that he found a striking absence of polymorphonuclears in the Delhi sores examined by him and in

which he found parasites corresponding to the Helcosoma tropicum of Wright or the Leishman-Donovan bodies.

Strong refers to a third type of tropical ulcers in which there were various clinical manifestations but in which there were found staphylococci. Such cases were frequently observed at Canacao and presented all types clinically from simple vesicles to pemphigoid lesions and from impetigo-like pustules to extensive erysipelatoid areas going on to necrotic processes and spreading ulcerations. In one case the abdominal muscles were involved. All of these cases showed in smears an abundance of a diplococcic organism which upon culture gave all the characteristics of the staphylococcus pyogenes aureus. Although culturally the same organism yet in its clinical manifestations of virulence and variations as to phagocytosis observed in stained films it would appear to be an organism of wide range of pathogenicity.

Wherry and Clegg described such an organism under the name of Diplococcus pemphigi contagiosi.

Woolley (J. A. M. A., March 2, 1907), considers that Dhobie's itch is an important factor in tropical ulcer.

After a study of a large number of such cases in which at times I found various moulds of different types in profusion, and again, after repeated examinations, nothing whatever to account for the extensive erythema, I am very skeptical of the existence of any specific organism for this exceedingly common affection. In several of our cases of tropical ulcer there was no history of Dhobie's itch and the large number of cases of the latter affection did not furnish but a very occasional case of tropical ulcer, so that I am sure the coexistence of the two diseases could only be of the nature of a coincidence.

There is one point about fulminating cases of Dhobie's itch, however, which I have noticed and which I have never seen brought out, and that is that in such cases a symbiosis seems to exist between an infecting mould and coccus. In the midst of a mass of mycelium in a smear one would observe areas studded with staphylococci. These cases showed a virulence far surpassing those cases in which only a mycelium and its spores were demonstrated. Whether the symbiosis increased the virulence or whether the cocci facilitated the extension of the mould I am unable to conjecture.

The foregoing clearly brings out the negative character of the etiological consideration of tropical ulcer as observed by me in the Philippines. As regards therapeutical considerations, I feel con-

strained to follow the views of Osler as to whooping cough—in other words, I should sum up the treatment of tropical ulcer as four months of development, four months of ulceration and four months of cicatrization. The French do well to call it the *bouton d'un an.*

It is needless to state that we tried every ordinary treatment that had ever been suggested. Among the special treatments which were tried and which at times appeared to give favorable results, but which again were without effect, may be mentioned:

1. Pepsin and hydrochloric acid locally (artificial gastric juice).
2. Ice bags.
3. Excision of the entire lesion. (In every instance in which this was practised additional lesions made their appearance).
4. Thorough cauterization with pure carbolic acid and after one or two minutes neutralization with alcohol. (On the whole this gave the most favorable results).
5. Bier's passive congestion method. (This was very painful and did not benefit in the least).
6. Massive doses of potassium iodide combined with rest. (Apparently of benefit in some cases).

I have to thank Assistant Surgeon H. W. Smith, U. S. Navy, for the use of the notes of some of his cases and for valuable suggestions in the preparation of this paper.

OBSERVATIONS ON SKIN DISEASES IN THE NEGRO.

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(*Concluded from page* 79.)

It is with a proper realization of its magnitude that I approach the subject of syphilis in the negro. It may be well at the start to call attention to certain changed conditions between the negro of slavery times and the negro of to-day. I agree with certain writers who claim that from a physical standpoint, the negro slaves were infinitely better off than are their descendants of to-day. Slaves, being valuable property, were treated as such and were well fed, housed and clothed. They were further absolutely kept from dissipation. When freedom came, all was changed. Close crowding in poorly ventilated houses, poor clothing and food, and failure to observe the ordinary laws of hygiene are the causes that have changed them, as McHattan says, from the most healthy race in the country, forty years ago, to the most diseased one to-day. An utter lack of morality (Quillian stating that in a practice of sixteen years he had never examined a negro virgin over fourteen), a strong sexual instinct and lack of cleanliness, seem all that are necessary to have brought about a widespread infection with syphilis.

That syphilis in the negro is not only very prevalent, but more so than in the white, is one point upon which the majority of writers, my correspondents and statistics agree. My table shows two hundred and seventy-nine cases of syphilis in the white and five hundred and ninety-six cases in the black, or twelve and twenty-seven per cent. respectively of the totals for each race. Morison gives sixteen and twenty-three per cent. respectively for both races, and Dyer twenty-six per cent. for blacks. Matas shows a proportion in a thousand cases of twenty-eight whites to fifty-one blacks. I have compiled a second table from the Central Dispensary reports for nine years, including all cases of syphilis which were treated in the clinics for medicine, surgery, children, gynecology, throat and chest, skin, genito-urinary and nervous diseases. In a total of fifteen thousand whites in round numbers, there were six hundred and twenty-one cases of syphilis, while in a total of thirty-two thousand blacks, there

were roughly nineteen hundred cases of syphilis. In other words, while there were two blacks to one white who applied for treatment, there were three blacks to one white suffering from syphilis. To be exact, the blacks suffered 1.46 times as often as the whites. From all these figures I think it can safely be inferred that syphilis if not almost universal as Murrell claims, is at least more prevalent in the negro than in the white race.

The question of the relative severity of syphilis, in the two races, is a much more difficult one than that of relative frequency. That acquired syphilis is not more virulent in the negro, but possibly less so, I am inclined to think from the following reasons. First—that the primary and secondary manifestations do not appear to be more severe. Second—that tertiary manifestations do not seem to be more common. Third—that in the negro the disease seems more amenable to treament.

It may be stated as a general rule, that negroes do not realize the importance of syphilis and are rarely willing to continue treatment after visible manifestations have disappeared. When they do submit to treatment, the disease responds more readily, I think, than in the white race. In speaking of syphilis, Byers writes, " it is more amenable to treatment than in the white race." According to Powell, " the disease is far more amenable to treatment in the negro than in the white, the cases yield readily and the cures are more permanent and satisfactory." " Twenty-eight years of experience in the practice of medicine in the South," writes Dixon, " have convinced me that the only difference in the two races is that the disease yields more kindly to treatment in the negro race."

A greater tendency to pustulation in secondary syphilis of the negro might be considered proof of its greater virulence in this race. Atkinson in speaking of his cases of pustular syphilis in a paper on early syphilis in the negro, says the " course of the pustular eruptions was uniformly benign," and further, " the presence of pustulations was no evidence of special severity of the disease and generally no unusual refractoriness to treatment was encountered."

In an attempt to see whether some of the severe tertiary lesions of syphilis were more frequent in the negro than in the white, I have tabulated cases from the surgical clinic of the Central Dispensary designated as syphilitic ulcer (most of them situated upon the leg.) It has given for this form of tertiary syphilis a proportion of 154 cases in the black to 100 in the white. A similar table from the throat clinic comprising cases of syphilitic ulceration of the larynx,

pharynx, palate and nasal bones (the majority presumably tertiary) gave a proportion of only 131 blacks to 100 whites. Figures from the clinic for nervous diseases, show a proportion of 366 cases of cerebral syphilis in the black to 100 in the white, and on the other hand only 104 cases of locomotor ataxia in the black to 100 in the white. Hecht has called attention to the fact that although syphilis is extremely prevalent in the negro, locomotor ataxia is rare in this race. As my table of eight clinics showed the proportional frequency for all cases of syphilis to be 146 blacks to 100 whites, it is seen that with the exception of the cerebral syphilis, the tertiary lesions men-

TABLE III.

SYPHILIS.

Disease	Clinic	Whites			Negroes		
		Total Patients Applying	Cases	Percentage	Total Patients Applying	Cases	Percentage
Grand total of all cases of syphilis	Eight different clinics	15672	621	.0396	32537	1895	.0582
Syphilitic ulcer leg	Surgical	4072	70	.0171	6873	182	.0264
Syphilitic ulceration of pharynx, larynx, palate and nasal bones	Throat	2152	82	.038	4700	235	.05
Cerebral syphilis	Nervous	990	15	.015	739	41	.055
Locomotor ataxia	Nervous	990	9	.0090	739	7	.0094
Congenital syphilis	Children	2954	23	.0077	4631	81	.0181

Statistics from Central Dispensary, 1898 to 1906. (Congenital syphilis, 1897 to 1906).

tioned above did not show any unusual frequency in the negro. The writer is fully aware that the figures are small and only deal with a few phases of such a varied disease as tertiary syphilis. They cannot do more than convey a suggestion as to the virulence of this disease.

In expressing an opinion upon the severity of syphilis in the negro, I have had in mind only the acquired form of the disease. That the hereditary form is more virulent and is an important factor

in raising the negro mortality, I think probable. According to Hoffmann, the mortality from premature and stillbirths, is greater in the negro than in the white. Corson writes, " I believe the direct mortality from syphilis in the negro is chiefly to be found in the ante-natal mortality and in that of early babyhood." A table compiled from the children's department of the Central Dispensary, shows in an equal number of patients, two and a third times as many hereditary syphilitic children in the blacks as in the whites.

In answer to the question " Is syphilis more virulent in the negro? " the majority of my correspondents have answered in the negative, and some have added, " less virulent." Certain others, however, whose opinions carry great weight, consider syphilis in the negro to be more virulent.

Surgeon Carter in a comparative study of 231 cases of syphilis in the two races, concludes that the disease pursues a milder course in the negro than in the white. In speaking of the negro, Kinloch says, " I do not think he is affected to the same extent (as the white) by syphilitic poison." Quillian writes, "one thing is certain, the lesions are not as severe in the black as in the white race." Although the figures of Matas give a mortality three times as great for the blacks as for the whites, he concludes that " if the mulattoes could be eliminated from the calculation the results would prove, other conditions being equal, syphilis to be less virulent and less fatal in the pure negro than in the white.

In considering some of the peculiarities of syphilis in the negro, attention is first called to those of the initial lesion. According to Morison, the chancre is attended by a greater amount of induration. Lofton states that it has been his experience to " observe as a rule double chancre (especially when located upon the genitalia or its covering) in the negro subject." Multiple chancre occurred in seventeen out of forty-five cases reported by Atkinson. The latter writer lays stress upon the modification of syphilis in the negro due to the great prevalence of scrofula. This is seen, for instance, in the marked inflammatory action of the glands in relation to chancre.

That general enlargement of the lymphatic glands is more constant and more marked in the negro, no one, I think, will dispute. In Dr. Carter's table enlarged glands were noted in fifty-nine whites and in one hundred and two blacks. Tiffany states, " enlargements of lymphatic glands are apt to be marked in the syphilitic negro compared with the white race." That the pustular syphilide in the negro is somewhat more common than in the white seems probable.

According to Tiffany, " excessive pus formation occurs in the negro not only with scrofulous affections, but with syphilitic as well." Carter states that in the negro, syphilis is marked by few cutaneous lesions, and these mainly pustular. A peculiar appearance has been observed by Taylor in two cases of papular syphilis in the negro. The eruption consisted of large flat papules, " nearly of a snow-white in spots where the skin was kept clean, and of a dirty-white elsewhere." Reference to lesions of the mucous membrane and to the occurrence of pruritus in syphilis will be made later.

If I were asked what I considered from my experience to be the most striking dermatological peculiarity of the negro, I would say without hesitation, the annular syphilide. (See Figs. 3, 4, 5 and 6.) This form of syphilis, it seems to me, should be classed with keloid and elephantiasis as affections that are very common and distinctive in the negro. Comparatively little has been written about the annular syphilide, and still less on its relation to the negro. The subject has been ably discussed by Atkinson in a paper entitled " Syphiloderma Papulosum Circinatum." This title well describes the condition to which I have reference, the lesions being simply flat papules that have cleared up in the center and then left elevated rims to form various-sized circles. The eruption as you well know, is one of the early period of syphilis, and is to be sharply differentiated from the circinate grouping of tubercles of late syphilis. I have seen the annular syphilide most often about the nose and mouth, though it may also occur on the trunk and upper extremities. Though I have only seen the eruption in the form of partial or complete circles or festoons, it may assume extremely fantastic designs resembling scroll work, an example of which is shown in the extraordinary photograph kindly given me by Dr. Carmichael. A somewhat similar though less well marked illustration is shown by Jullien in his Maladies Vénériennes. Fine illustrations of the annular syphilide are to be seen in the atlases of Wilson, Taylor, Morrow and Pringle, but no reference is made to the disease in the negro. Photographs of the annular syphilide in the negro appear in the text books of Stelwagon and Pusey, and both of these writers state that the disease is more common in the black than in the white. In my statistics obtained from the Johns Hopkins Dispensary, out of a thousand consecutive cases of skin disease in the white, there were seventy-two cases of syphilis, none of them presenting the annular form of the disease. In the corresponding 1000 cases in the negro, there were one hundred and ninety-three cases of syphilis, eleven of which, or .057 per cent., presented examples

of the annular syphiloderm. Finally, it may be remarked that the diagnosis is uniformly easy, though to one unfamiliar with these lesions, the eruption might readily be mistaken for the annular form of erythema multiforme or for ringworm.

Of the benign tumors of dermatological interest, I should like to call your attention to one that is characteristic of the negro, namely, keloid. In an effort to obtain as large figures as possible upon this subject, I have tabulated the cases from the surgical and from the ear departments of the Central Dispensary. These figures added to those of my general table, give a total of three cases of keloid in the white, and the rather surprising number of seventy-six

TABLE IV.

TUMORS.

Disease	Clinic	Whites			Negroes		
		Total Patients Applying	Cases	Percentage	Tota Patients Applying	Cases	Percentage
Angioma ...	Surgical and skin	6272	1	.000159	9073	3	.00033
Carcinoma ..	Surgical and skin	6272	13	.00207	9073	16	.00176
Epithelioma.	Surgical and skin	6272	46	.00733	9073	5	.00055
Fibroma	Surgical and skin	6272	7	.00111	9073	14	.00154
Keloid.....	Ear, Surg. and skin	8382	3	.00035	11486	76	.0067
Lipoma.....	Surgical and skin	6272	5	.00079	9073	39	.00429
Papilloma...	Surgical and skin	6272	22	.00350	9073	27	.00298
Sarcoma	Surgical and skin	6272	7	.00111	9073	12	.00132

Statistics from Surgical Clinic of Central Dispensary, 1898 to 1906, plus figures given in Table 2. Statistics for keloid contain in addition cases from Ear Clinic, 1898 to 1906.

cases in the black. In proportion to the total patients of each race treated in these clinics, keloid was eighteen and seven-tenths times more frequent in the negro than in the white. The figures of Matas from a small number of cases show keloid to be nine times as frequent in the negro. Morison's table gives three cases in the pure black and none in the mulattoes or whites. Dyer states that in 2538 cases of skin disease, twenty-one per cent. of which were negroes, he observed five cases of keloid in whites and only three in

blacks. The small number of cases in the negro was explained by Dr. Dyer from the fact that the negro rarely seeks medical assistance unless compelled to do so by unbearable conditions. Balloch calls attention to the fact that in the statistics of the American Dermatological Association for keloid, although no mention is made of color, the majority of cases are reported from cities having a large negro population. The same writer saw nine cases of keloid in one hundred and fifty-two blacks and no cases in three hundred and ninety-two whites. The statistics of James C. White, give fifteen cases of keloid in 10,000 American Dispensary cases, among which were doubtless many negroes. There were five cases of keloid in 10,000 Scotch patients, and none in 3000 Irish patients, all of which were presumably white. In 23,944 cases from the Vienna Clinic, one case only of keloid was reported. That the lobule of the ear is a very favorite site for keloid is seen from my figures which record for this situation twenty-four cases, eighteen of which were females. Scheppegrell, in 11,855 cases of diseases of the nose, throat and ear, found eight cases of keloid of the lobule, seven of which were negroes, one a mulattress and one a white person.

From all of these figures it can readily be seen why keloid is so often classed as one of the three common and distinctive diseases of the negro, the others, as you know, being elephantiasis and uterine fibroid. According to Balloch, fibroid processes as represented by these three affections are so much more common in the negro that they constitute a racial peculiarity.

In connection with keloid I should like to remind you of the frequency in the negro of an allied affection, the so-called keloid acne or dermatitis papillaris capillitii of Kaposi. That this disease is very common in the negro as compared with the white, is seen from my figures giving ten cases for the former and only one for the latter. A number of illustrations of this peculiar condition are to be seen in my exhibition of photographs. (Figs. 1, 7, and 10.)

A glance at my table of tumors, which is unfortunately of very meager proportions, shows papilloma to be about equally frequent in the two races. Angioma is twice as frequent, and lipoma nearly five and one-half times as frequent in the negro as in the white. Of the malignant growths, sarcoma is slightly more common and carcinoma slightly less common in the negro than in the white.

It is not my intention in this paper to discuss the general subject of cancer in the negro. I wish merely to call attention to that form of malignant growth of such importance to the dermatologist,

namely, cutaneous epithelioma. In this affection we appear to have another example of the lessened susceptibility to skin diseases that is enjoyed by the negro. Epithelioma in my table appears thirteen and three-tenths times as often in the white as in the black. In Tiffany's statistics there is not a single case of epithelioma of the face or lip of a negro. Yandell stated that he had never seen an epithelioma on the face of a negro. Christopher Johnston said that he had only infrequently met with epithelioma in the negro race, and nearly all with whom I have corresponded have had a similar experience.

Some very interesting figures and conclusions are given by Hyde upon this subject in a recent contribution on the "Influence of Light in the Production of Cancer of the Skin." The figures which relate to deaths from cancer of the head, neck and face (practically that of the skin) are taken from the last census reports of two Southern States of about equal population. The returns lack only ten of reporting twice as many fatal cases of cancer in the northern as in the southern states. This appears significant when it is considered that half the population of the southern states consisted of negroes. The writer concludes that the physiological pigmentation of the skin in the colored race seems to furnish immunity against cancerosis of that organ. Finally, although firmly convinced that epithelioma in the full-blooded negro is decidedly uncommon, I must in fairness mention the fact that the statistics of Richardson actually show a greater frequency of epithelioma in blacks than in whites.

I have long been under the impression that itching was a more or less characteristic feature of skin affections in the negro. This would appear to be borne out by my statistics giving about twice as many cases of pruritus of different forms in the blacks as in the whites; while the figures of Morison record twenty-four cases of pruritus in pure blacks and five in whites. Since my attention has been specially directed to this subject, I have concluded that while negroes may complain of itching more often than whites, the visible results of scratching are certainly much more marked in the latter race. It is probable that the papular syphilide, though giving rise at times to pruritus in the white, is more likely to do so in the negro race.

Of the pigmentary diseases vitiligo appears in my table more frequent among the blacks, the proportion being six blacks to four whites. (Figs. 11 and 12.) Morison's figures show four cases in the black to one in the white. On the other hand, chloasma appears

in my table to be twice as common in the white as in the black. That these figures do not represent the actual conditions, I feel perfectly confident. It is natural that a negro with such a striking affection as vitiligo would be more apt to seek medical aid than a white person with the same disease, whereas the conditions would be exactly reversed in the case of chloasma. Atkinson considered that vitiligo was only apparently more common in the negro, not actually so. Chloasma in the pure black would often pass unnoticed. In the mulatto, however, it is noticeable and of more frequent occurrence than in the whites, in my opinion. Rutz stated that chloasma was remarkable for its frequency and extent in mulatto women. Atkinson also considered chloasma to be especially common in those of mixed descent. Whether pigmentation following inflammatory and other lesions is more common in the pure black than in the white, it is difficult to judge for obvious reasons. That it is more common in the mulatto than in the white, I feel convinced.

A comparison of the parasitic diseases in my table shows 243 cases of scabies in the white and 170 in the black. There were fifteen cases of pediculosis corporis in the white and twenty in the negro, a rather small number for the latter, considering his uncleanly habits. The figures for pediculosis capitis show a rather striking disproportion, namely, 54 cases in the white and only 5 in the black. This might indicate that the negro scalp is less irritated by the presence of pediculi and that he in consequence does not seek the clinic as often as the white. It may, however, indicate that the negro takes greater pains in the care of the scalp than the lower class of whites that attend our clinics. Dr. Carmichael informs me that the negro women in Virginia take a special pride in keeping their heads and those of their children free from lice. Dr. Pendergast of Memphis, suggests that negro women unconsciously and of necessity employ one of the methods of treating pediculosis, namely, the fine tooth comb. In contrast to the figures for pediculosis are those of tinea capitis which show seventeen cases in the white and fifty-six in the black. A similar proportion is given in Morison's statistics with fourteen whites and forty-two blacks. Both favus and chromophytosis appear in my table slightly more common in the negro than in the white.

My figures for seborrhœa show eighteen cases in the white and twenty-three in the black. On the other hand there are twelve cases of alopecia in the white and only one in the black, representing in my opinion the relative proportion of baldness in the two races.

Alopecia areata appears ten times in both races, a rather high proportion for the blacks, it appears to me. It is well known that canities makes its appearance considerably later in the negro than in the white, marked grayness being a sure sign of advanced age in the former race.

It may not be out of place in this paper to show some evidence that the mucous membrane of the negro shares with the skin a lessened susceptibility to disease. According to T. E. Murrell, "in the adult negro nasal and pharyngeal diseases are quite infrequent." Scheppegrell states, "in the diseases of the nose we find a proportionately small number of negroes affected." The same writer gives some figures showing the proportion of diseases of the mouth and tongue to be forty-two blacks to one hundred whites. Carter states that the mucous membranes of the negroes are less vulnerable to syphilis than those of the white. In his table of syphilitic lesions of the mouth and fauces, there were thirty-nine cases of hyperæmia of the fauces in the white and only six in the negro, though the writer admits that this condition is probably more common than is here indicated. There were, however, thirty-one cases of mucous patch in the white and none in the black, a disproportion that is indeed striking. My attention has lately been called to the rarity of leukoplakia in the negro, while studying a case of leukoplakia buccalis which I have been fortunate enough to have under my charge. (See Figs. 8 and 9.) I have again called upon my correspondents for aid and addressed the question: Have you seen many cases of leukoplakia in the negro? As in the case of psoriasis, the question should have read: Have you ever seen a single case? Most of my colleagues answered simply "No." Four stated that they had seen several cases. Dr. Carmichael had seen "one case in a full-blooded negro," while such good observers as Drs. Dyer, Engman, Grindon and Mastin stated that they had never seen a case of leukoplakia in the negro. I have been unable to find any reference in text books on dermatology or syphilis to this peculiar immunity enjoyed by the negro.

That the negro may suffer as well as the white man from some of the rarer diseases of the skin, is seen from my list of affections in which one case of each disease was recorded. Included in this list are blastomycosis, herpes iris, lichen ruber, lichen scrofulorum, morphœa, mycosis fungoides, Paget's disease, pemphigus and Henoch's purpura. The case of blastomycosis was one of the two negroes that have been reported by Dr. Gilchrist. The only case of blastomycosis which it has been my fortune to treat is that of a

mulatto with a lesion upon the buttock, an illustration of which also appears in my collection. One case of ainhum is recorded in my statistics which, like nearly all of the cases of this peculiar disease, was noted in a negro. My figures, strange to say, do not include a single case of elephantiasis.

A consideration of the exanthemata opens up such a large field for discussion that I have felt it advisable to omit any reference to this subject, and devote my time to those more strictly dermatological.

Finally, I should like to express a single opinion upon the relative susceptibility of the negro and the mulatto to skin diseases. I feel convinced that in general the mulatto is more susceptible to diseases of the skin than the full-blooded negro, this being especially true of acute inflammatory diseases, chloasma and cutaneous tuberculosis.

CONCLUSIONS

1—In spite of the fact that the negro is more susceptible to disease in general than the white man, and that his mortality is twice as great, he suffers less frequently and less severely from diseases of the skin.

2—The negro skin is decidedly less susceptible to external irritants.

3—The full-blooded negro is almost immune to ivy poisoning.

4—Acne is less common and much less severe in the negro. Rosacea is a rare and very mild affection. Eczema is perhaps not less frequent though certainly less severe. Psoriasis in the full-blooded negro is very uncommon.

5—Tuberculosis of the skin is not more common in the negro in spite of the great prevalence in this race of pulmonary and other forms of tuberculosis.

6—Syphilis is certainly more common in the negro than in the white. It is probably not more virulent. Tertiary forms are not more common. A tendency to the annular syphilide as well as to keloid, elephantiasis and fibroma, deserves to be classed as a racial peculiarity of the negro.

7—The negro is more subject to new growths of connective tissue origin and less so to those originating in epithedial structures. Cutaneous epithelioma is very rare in the full-blooded negro.

8—The mucous membranes as well as the skin are less susceptible to disease. Leukoplakia is seen in the negro with extreme rarity.

9—Many of the rarer forms of skin disease are observed in the negro as well as in the white race.

10—Mulattoes are more susceptible to skin diseases than negroes, being especially prone to chloasma.

In closing, I desire to express my thanks to Drs. Gilchrist and Carmichael for their kindness in putting the statistics of their clinics at my disposal. I am also indebted to Dr. Grindon for a long letter containing many valuable suggestions. Finally, I must express my deep gratitude for the assistance so kindly rendered by my numerous correspondents scattered throughout the South.

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SOME EXPERIMENTAL OBSERVATIONS ON THE HISTO-PATHOLOGY OF URTICARIA FACTITIA.

By T. Caspar Gilchrist, Baltimore, Md.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

THE author exhibited about sixty lantern slides demonstrating the histo-pathology of wheals which were produced artificially by drawing down the finger nail or a blunt instrument rather sharply over the skin of patients suffering from urticaria factitia, no other disease being present. Fifteen cases were examined but the lantern slides represented micro-photographs of sections taken from only seven of the most pronounced cases of this disease. Usually the lesion was excised fifteen minutes after the wheal was produced, but in one case portions of wheals were excised after two minutes, five minutes, eight minutes, fifteen minutes, twenty-five minutes, forty minutes and sixty minutes. In the section excised after three minutes there was present fragmentation of nuclei which seemed to show death of cells preceding the inflammatory changes which followed. Sections of the wheals from severe cases showed marked œdema, of the connective tissue and the fixed cells, profuse emigration of polynuclear leucocytes, emigration of lymphocytes, pronounced fragmentation of polynuclear leucocytes and fixed connective tissue cells, apparent increase in mast cells, swelling of the cells of the sweat glands, and fibrin scattered throughout the corium. In the sections excised one hour after, many polynuclear leucocytes were still present but very little fragmentation was noticed. Portions of normal skin were excised under similar conditions so that proper comparisons could be made.

In one very severe case the polynuclear leucocytes were nearly all fragmented almost directly after leaving the blood vessels. In all the cases the wheals usually disappeared clinically within an hour. The pathological picture is undoubtedly one of typical acute inflammation (Cohnheim) and the fragmentation of nuclei is as remarkable as that produced by diphtheria toxin (observation by Dr. William Welch, after carefully going over the specimens).

The only explanation which appears to be possible is that some toxin is circulating in the blood and when a wheal is produced some of the toxin is set free and produces death of cells which is followed by acute inflammatory changes. Therefore a true wheal is an acute inflammatory œdematous swelling due either to local inoculation of irritating substances, as in insect bites, etc., or to drugs or to some toxin probably originating in the alimentary canal.

The author's observations have extended over the last thirteen years and references to his earlier experiments are to be found in Duhring's text book on cutaneous medicine, Vol. I, p. 129 (1895); also Vol. II, p. 293, and in the Johns Hopkins Bulletin, Vol. VII, No. 64, p. 141 (1896).

THE EFFECTS OF ROENTGEN RAYS ON PAGET'S DISEASE OF THE BREAST

By Dr. Roberto Terzaghi and Professor Campana.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

SOME forms of apparent psoriatic eczema on the breast often do not receive medical attention, and may at times assume a chronic and malignant form, as of epithelial tumor, a form that has been named from the author first describing it, "Paget's Disease." It is not about the nature of this affection that we wish to speak, but simply of the results obtained with Roentgen rays in cases that threatened to assume the above named form of disease.

We will quote, in this connection, an experiment with the relative results obtained by means of a certain number of applications of Roentgen rays in two cases.

CLINICAL HISTORY

Diagnosis—Eczema psoriasiform of the breast (incipient Paget's disease). Nutrition good, skeleton development regular, stature above the mean, skin somewhat pallid. On the skin of the chest, the nipples, mammary areolæ and adjacent parts showed a slightly humid maculo-squamous eruption, the scales were broad and coriaceous, indifferently adherent, and humid on the lower side, the underlying skin thickened, somewhat hardened, little movable in its

different layers and little developed on the subcutaneous nipple. Microscopic examination of the scales showed no pathogenic mycotic forms; there were the usual corpuscles described in psoriasis. On the rest of the body a few lentiform papules at very great intervals on the back and on the thighs. Slight itching sensation. Genital organs normal. No pathological product in the urine. Different functions normal.

The patient began to suffer in the breasts about three years previously and had experienced no improvement from various methods of treatment undergone at her home.

From the first application of the rays, we began to notice a modification in the resistance of the epithelial cutaneous cells especially in the periphery of the mammary areola, first on one side, then on the other, and afterwards on the rest of the periphery of the nipple, which was the part most affected: more persistent adhesion of the epithelium, diminution of the dermic swelling; not remarkable, yet evident, return to their normal state of the lines and folds of the skin of the nipple; gradual diminution of the humid condition where the corneous stratum was still wanting.

The experiment of the application of the same methods was repeated on another case, and with the same favorable results.

These two experiments do not seem to me without interest, when we reflect on the extremely malignant course the process assumes in sequence to phases similar to the cases related by us.

SOCIETY TRANSACTIONS.

THE NEW YORK DERMATOLOGICAL SOCIETY.

353d Regular Meeting, December 17, 1907.

Dr. E. B. Bronson, President, in the Chair.

A Case of Ichthyosis Hystrix. Presented by Dr. Winfield.

The patient, a girl aged eleven, native of the United States, German parents; at birth the skin was scaly, more marked over the lower part of the abdomen and legs and arms. The other children of the family are healthy; there is no history of fright or any other untoward condition of the mother during this pregnancy.

Present condition: The child is an undersized girl with blunted intellect. The ichthyotic condition is more marked over the arms, neck, scalp, lower part of the abdomen, thighs, and legs. The face is slightly scaly; the skin of the palms and soles appears normal; if the skin is not constantly oiled it becomes eczematous; at times the ichthyotic scales desquamate, leaving the skin almost normal in appearance.

Dr. Sherwell agreed that it was ichthyosus hystrix, but that the inspissated seborrheal element was in excess of the epithelial. He remembered the case as having been under his care some years ago. It had cleared up at that time with a moderately strong ointment of hydrarg. ammoniat. and salicylic acid.

Dr. Johnston said that a possible element in the etiology of ichthyosis is diminished thyroid secretion. It would do no harm to try its administration and it might do a great deal of good. Recently he had had a clinic patient, a woman who was not only ichthyotic herself but had borne two harlequin fœtuses, both of which died a short time after birth. One of these was autopsied, and there was almost complete absence of the thyroid. The woman herself had the habit of clearing up to a considerable extent during pregnancy, but returned promptly to her previous state when the pregnancy was over. She had five children in all, three of whom were normal.

Dr. Fox was pleased to see so well marked a case of ichthyosis hystrix. A number of cases have been reported in dermatological literature which have been simply nævus linearis, not ichthyosis at all. This is an undoubted case.

Dr. Winfield said that the patient had been under the care of several physicians for a number of years, and he inferred that thyroid treatment had been used. He had observed two cases of ichthyosis congenita spoken of by Dr. Johnson; one had been autopsied and no thyroid was found; he had used thyroid extract in cases of simple ichthyosis, but with no effect.

The child shown to-night is undoubtedly stupid, and appears as if she had adenoids, although they had not been looked for. Instead of the thyroid being absent it appeared to be hypertrophied. It was his intention to examine for, and remove the adenoids, if found, and put the patient upon powdered thyroid.

Dr. Fordyce also thought it might be of interest to try thyroid treatment.

He did not think, however, that it would have any more effect in this case than it would in any other congenital nævoid condition.

Dr. Sherwell also had seen the case of ichthyosis congenita (harlequin fœtus), referred to. The child lived and had a hard thickened skin that looked like the hide of a rhinoceros. It lived under linseed oil treatment for five months. It lived an unusually long time, he believed the longest on record. He had written up and published the case.

A Case for Diagnosis. Presented by Dr. Sherwell.

Jennie E., aged fourteen, first came to the clinic with frank psoriasis of the head, on October 14, 1907. She was treated with ammoniated mercury, resorcin gr.x. and salicylic acid grs.v., acid chrysophan iii., to vaseline oz. i., with rapid and good results—entire cure. A month or more later the present eruption appeared, and has not yet yielded to treatment. This peculiar gyrate form of trouble on body came on about a month later. It now resembles a case of dermatitis seborrhoica with unusual formation of impetiginous bullæ, here and there, he thinks the application of the same ointment as used on head may account for this as the skin seems unusually sensitive.

Dr. Fox did not think it psoriasis, but a form of circinate impetigo. He had seen a number of cases of limited extent resembling this. He was not sure that they were of precisely the same nature as the common contagious impetigo, but was closely related to it.

Dr. Dade said that from a distance the picture presented did resemble psoriasis, but on closer inspection the borders could be distinctly made out to be vesicular, such as are seen in acute ringworm, derived from animals. He strongly suspected ringworm of this nature and would like to examine this microscopically—the rings and festoons being confined to the body—though lesions having been in the head, the hands—face, arms, and legs remaining free, with absence of any of the crusts that are so typical of impetigo, would hardly hold for this diagnosis. Psoriasis it was not.

Dr. Fordyce would not make a diagnosis without further observation and investigation. In his opinion, however, the case was one of serpiginous impetigo contagiosa. In some of these cases it was not easy to make a differential diagnosis from some forms of tinea circinata. The primary lesion in this instance, however, seemed to be a bulla which soon became crusted.

Drs. Jackson and Whitehouse agreed with Dr. Fordyce. Another member thought it was impetigo contagiosa.

Dr. Sherwell said that he had not presented the case as psoriasis, but as a lesion which commenced in the scalp and appeared like a psoriasis. It was cured, and a month or more later some other lesions appeared. It is a question whether the ointment used, although mild in character, had not produced a dermatitis. The ointment has been stopped and the patient put upon inunctions of sweet almond oil, and she has improved under the latter treatment. She seems to be a strumous child and one whose skin is easily affected. Dr. Sherwell said that he himself had made no diagnosis. It seems to be a form of impetigo. He had only seen the child once or twice within last few days.

Pemphigus Vegetans. (?) Presented by Dr. Johnson.

The patient is a woman past forty years of age. The lesions occupy the usual sites of this type of bullous eruption, axillæ, groins, etc. When she first came to the clinic there were no evidences of bullæ. The areas involved showed these elevated patches covered with serous crusts bordering wide areas of pigmentation. There were so many features in the eruption which suggested syphilis, that a week ago she was put upon specific treatment, with the result that her already disturbed digestion was completely upset, and she has now an outbreak of blebs and vesicles in the same regions, occasionally grouped and itching excessively. Observation reveals an evident element of vegetation, either dermatitis vegetans, or possibly a beginning pemphigus vegetans. She has had this eruption now for about four months altogether. In spite of gastro-intestinal disturbance which is very marked, the urine was normal; the blood count showed nothing before the present relapse. Experience with pemphigus vegetans is of course very limited, but with the tendency in the skin to vegetation, the localization, and the pronounced depression that seems the probable ultimate diagnosis.

Dr. Fox said that the localization of the eruption is similar to many cases seen in children, with large bullæ at the margin of the patches. This runs an acute course, with frequent relapses and is generally termed pemphigus.

Dr. Winfield did not think it pemphigus vegetans on acount of the appearance of the lesion and the itching.

The localization near the groins might suggest that diagnosis, but in his experience pemphigus vegetans started differently; the mucous membrane of the mouth, or the skin about the finger nails were first involved. Several years ago he had a patient, a man, who after vaccination had an eruption of bullæ in the groin and axillæ; the appearance was much the same as in the case shown to-night; the lesions involved the groins, scrotum, and axillæ; early in the course of the disease there had been some vegetations; finally the eruption spread all over the body, assuming the character of true dermatitis herpetiformis; the man still has occasional outbreaks, although they are much less severe in character; he has had no symptoms of pemphigus in all this time.

Dr. Fordyce would make a diagnosis of dermatitis herpetiformis with secondary dermatitis vegetans. He had observed two such ases over a period of several years and had not seen them develop pemphigus vegetans. The location of the lesions in the axillæ and inguinal regions recalled the case which he had reported in connection with Dr. Gottheil, under the name of dermatitis vegetans, and was also analagous to the cases described by Hallopeau and others as pyodermite végetante.

Dr. Jackson said that the lesions suggested dermatitis herpetiformis rather than pemphigus. He would not make the latter diagnosis until there were other evidences of it.

Dr. Whitehouse considered it to be dermatitis herpetiformis, on account of the lesions, and their being associated with intense itching. He would hesitate very much about calling it a pemphigus. He regards it as a case of dermatitis herpetiformis with vegetations due to secondary infection.

Dr. Sherwell considered it dermatitis herpetiformis of unusual type. The

mouth lesions are absent, and the mucous membrane of the boundary line at the vagina not being involved, he thought the diagnosis of pemphigus vegetans was improper, he would prefer to wait two years before making any diagnosis.

Dr. Johnston said that he was perfectly willing to stand corrected in the matter of the diagnosis; the first idea that came into his head on seeing the case was that it was a dermatitis herpetiformis, but he also made a tentative diagnosis of pemphigus vegetans at the same time. The case did not occur in the characteristic localization of dermatitis herpetiformis. Not only that, but the very marked depression that went with the acute outburst was impressive.

Dr. Lustgarten said that he had not thought of it at first, but the condition began about the menopause. He had never seen such a condition due to the menopause, but we do see a number of erythematous eruptions, and tentatively it might be well to give the patient ovarian extract and see whether it would make any impression on the condition.

In reply to an inquiry from Dr. Johnston as to whether he had ever obtained any good results from such treatment, Dr. Lustgarten replied that they had obtained some very excellent results.

Erythema Multiforme (Perstans). Presented by Dr. Sherwell.

Margaret McC., aged fourteen. First seen at the clinic in the fall of 1904. The lesion appears mostly on the hands and face, and reappears in colder weather and changes of season, fading in the summer. She comes from a malarial region and seems to have a tendency to rheumatism. Three years ago it seemed to be a characteristic erythema multiforme on backs of hands, etc.

He saw the patient a fortnight ago, after an absence of two years, and did not remember it at first. When he first saw the case some years ago he had put it down as erythema multiforme. The same thing continues now, and it fades in the same way. It comes out in the colder weather. The patient lives in an exposed place, near Greenwood. The parents are healthy, and the child also seems healthy.

Dr. Jackson said that it seemed to him the lesion on the face would ultimately become a lupus erythematosus. The occurrence of the parasitic lesions on the extensor surfaces of the forearms suggested a chronic urticaria. It seemed likely that the condition on the face and that on the arms were quite distinct. It certainly was unusual to see in an erythema such marked pruritus of the arms as in this case.

An Unusual Case of Lupus Erythematosus with Cutaneous Infiltrations Resembling Circumscribed Scleroderma.

Presented by Dr. Whitehouse.

Mrs. F. T., aged thirty-nine; married and has three children—twenty, eighteen, and fifteen years of age. The two eldest are perfectly well; the youngest was well up to two years of age, when she had cerebrospinal meningitis, since which time she has been an imbecile. Six years ago patient had a miscarriage at the fourth month, resulting from a severe fall. No history of tuberculosis.

Her skin affection began seven years ago, as a firm, circumscribed, painless induration in the skin over the right malar protuberance, the skin covering it being unaffected. The patient states that the original "lump," which was flat and about one by three-quarters inches in size, by very slow degrees "moved" across the face to the nose, where it now spreads over both sides of the nose in the form of an indurated symmetrical swelling, fading gradually into the surrounding tissues; the skin over it no win this location is devoid of scales, is bluish-red in color, and suggests a patch of morphœea. Over the left malar protuberance is another infiltrated patch, the skin covering it being the seat of a typical circular patch of lupus erythematosus about one-half an inch in diameter, with adherent scales, from the lower surface of which are tiny projections corresponding to the follicular openings. There is a similar patch of lupus erythematosus on the left temple, some smaller ones on the right cheeks, and a symmetrical band of baldness about two inches wide extending from each temple over the ears and meeting in the median line in back. The skin is perfectly smooth, shining, bluish-red in color, and apparently atrophied; near the posterior junction of the two bands, on the left side, is a recent circumscribed swelling, which the patient states illustrates the method of the progression of the disease. At this point there is more redness and a sensation of smarting, but when quiescent there are no subjective symptoms whatever in any of the lesions or areas involved.

Scattered over both sides of the lower jaw, both sides and front of the neck, and on the chin, are a dozen or more of these indurated plaques, apparently imbedded in the thickness of the skin, which is not movable over them, but otherwise appears normal. These vary in size from one-half to one inch in diameter; there is one subcutaneous nodule in the left sub-maxillary region; the lobe of the right ear is the seat of one of these infiltrations, the left ear being free. The skin covering the right zygomatic process feels slightly hidebound, as does also the skin over the chin.

The disease has changed the facies of the patient very materially. Both cheeks are deeply sunken beneath each malar protuberance, so that they are almost funnel-shaped, and the symmetry of the face is impaired by these cutaneous infiltrations. The skin of the cheeks is unnaturally loose and falls in small folds where it is not the seat of the disease. The face was formerly round and smooth, but there now seems to be a considerable loss of sub-cutaneous fat and muscle substance.

She has not lost flesh generally, has a good appetite, but complains of constipation. The menses are regular and normal. Since this disease began, however, she has had periodical attacks of very severe headache in the temples, lasting three days. Last winter and this she has also suffered from very cold hands and feet, with tingling and numbing of the fingers, and intense pain in the fingers often lasting an hour after being exposed only to a mild cold. She does not have the so-called "dead fingers," but states that the nails become dead white.

Dr. Sherwell said that he had been struck by the appearance of the face, which was very analogous to a case which he had presented before the Society some twenty years since. He had lost sight of the patient for fifteen years, and she is possibly now dead. It was then presented as a case of *double hemi-atrophy*, which of course was a contradiction of terms. The sinking in of the face was more marked than in this instance, but the history was very similar. The mummification and the hardening of all the tissue beneath the skin was very marked, the face looked like a death's head. There was first an hypertrophy and then a distinct atrophy of all the parts as in scleroderma ordinary. He promised to bring a picture of the case to the next meeting. The whole thing seemed to be a scleroderma, which involved the muscular tissue as well as the skin and subcutaneous tissue. She was plump of body and otherwise apparently healthy, and bore healthy children afterward, and seemed to get along very well.

Dr. Winfield said that he had seen the case referred to by Dr. Sherwell, and there was a great similarity in the history of the two cases.

Dr. Whitehouse said that he had nothing to add to the history. In daylight the circumscribed lesions on the face and temple showed every clinical evidence of lupus erythematosus; the other condition is apparently a circumscribed scleroderma. The patient states that the atrophy of the tissues of the cheeks was coincident with the original thickened patch below the eye, but it evidently followed it.

Dr. Fordyce said that last year he had presented a patient with sclerodactylitis and scleroderma of the face. She also had alopecia and red atrophic patches in the scalp which could not be distinguished from lupus erythematosus. The clinical picture was somewhat similar to this one excepting that his patient did not have the atrophy of the deeper structures.

Erythematous Eczema. Presented by Dr. Sherwell.

Mr. C., aged fifty-two. The present trouble commenced about the 20th of November and seemed to be of an erysipeloid nature. It was diagnosed as erythematous eczema, and when he first appeared at the office for treatment he was put upon a lotion of oxide of zinc and lime, camphor water and a little adrenalin solution. This was followed by a slight improvement. The condition seems to be an erythematous eczema with other adnexa, and he has been presented for a more accurate diagnosis, and suggestions for treatment.

The lesion appears only on the face and arms. The patient is a man of temperate habits, does not drink or smoke much. He gives a history of eating a Welsh rabbit with some friends on the 20th of November, and in two or three days all of the party had gastric disturbances (Ptomaine?), but he is the only one who has had any skin trouble. The urine has been examined and found negative. He is an agent or drummer, a busy man, and has to be out of doors a great deal, and is suffering now from being confined. The lesion itches considerably and smarts more. The urine when he first applied for treatment was scanty, but this has been increased by diuretic treatment. It has not been examined for indican.

There seemed to be a general agreement in the diagnosis. Dr. Fox suggested

that if the patient should lose ten or fifteen pounds in the course of the next two or three weeks by strict dieting he would get well quicker than on local treatment.

Tuberculosis of Right Hand. (?) Presented by Dr. Whitehouse.

This case was presented by Dr. Whitehouse at the January meeting of the Society for diagnosis. It will be remembered that the lesions involved the back of the right hand and wrist, were ten years in duration, and began from an injury by shoemaker's thread, the inflammatory lumps that developed being punctured by his shoemaker's awl. Four months previous to his coming under observation he suffered loss of vision in one eye, which improved while taking drops from the eye and ear infirmary. From his description these drops were undoubtedly iodide of potassium.

The question in January was whether it was syphilis or tuberculosis. The general concensus of opinion was that it was syphilis. A biopsy was made and smears taken, and the patient submitted to mixed treatment. He was presented again a month later, at the February meeting, with a very great improvement in the condition. The pathological report was presented at the same time, pronouncing it an epithelioma extending deeply into the subcutaneous tissue; cell nests or "pearls" were very numerous; smears from one of the large lesions and from the purulent thin fluid discharged from a smaller nodule were negative for tubercle bacilli, actinomyces, and spirochæta pallida; cultures gave a pure growth of streptococcus.

One or two of the lesions that had not yet yielded to anti-syphilitic treatment had an indolent warty appearance, and it was suggested that epithelioma might possibly exist, having developed upon the syphilitic base. Further anti-syphilitic treatment was advocated, and another pathological examination advised if all did not heal. He neglected treatment for two months, and returned early in May with the condition practically the same as when first shown. The same treatment was again instituted, together with mercurial plaster locally. He improved steadily until early in August when he again disappeared.

He returned yesterday after an absence of four months, during which time he had taken no treatment. The condition had improved so much that he went to work. Two weeks ago he fell, forcibly extending the thumb and forefinger of this hand, following which is the condition he presents to-night—a typical acute tubercular joint, with involvement of wrist joint and carpal bones. A serous fluid can be squeezed from some of the skin lesions, and there is a rather typical tubercular condition of the skin of the original area.

He is presented to-night, believing that in the light of subsequent developments the study of his past history, would be both interesting and profitable. He would call particular attention to the ten years' duration of this trouble, the manner of its inception, the eye condition and its im-

provement under potassium iodide, the great beneficial effects of mixed treatment, and the pathological findings from the skin sections, smears, and cultures.

Dr. Jackson said that he did not see that the present condition of the patient throws much light on the diagnosis. He has had a fall and has a sprained and swollen wrist. He would hesitate to call this a tubercular joint, for it has developed very recently and quickly. The original lesion got well under mercurial treatment, and from the present appearances he could not see that much progress had been made in the diagnosis. All things considered the evidence seems to be in favor of syphilis.

Dr. Fox was inclined to think the case specific in character—mainly from its appearance, and from the condition which is so often seen in the ankle. Many such cases used to be known at the New York Dispensary as the "syphilitic hoof," the bones being greatly enlarged with superficial nodules. He had several photographs of such cases, presenting almost the same appearance as this one. With the additional history of having improved under specific treatment, he would certainly be inclined to consider it of specific origin.

Dr. Piffard said that a course of specific treatment for three or four weeks should determine positively whether or not it was syphilitic.

Dr. Johnston said that he saw no reason for a change of diagnosis which could be determined by treatment. There was a history of considerable injury here, and the arthritic condition might easily be referred to the injury and not to a specific process. In other words, the man may have a sprained wrist, which will go down in time. If he uses it, it will not go down at all.

Dr. Whitehouse reminded the members that when the case was first presented it had certain tubercular features which were hard to deny, particularly the character of the discharge from the nodules. The young man was very emphatic about the serous character of this discharge, and also about the ten years' duration of the process; there had been no pus from the nodules at any time. The improvement on mixed treatment had been more marked he thought than would occur in a plain tuberculous case, and the occurrence of the eye trouble and its disappearance under iodide of potash would seem to point clearly to there being syphilis also present. He felt confident that the present condition is tuberculous, and saw no reason why the two should not exist, one changing the character of the other. He did not see how the eye trouble could be reconciled with the tubercular joint, which has been so pronounced by competent surgeons. The only way to do is to accept that he has both conditions. Subsequent progress of the case will be reported.

Adenoma Sebaceum of the Chest and Back. Presented by Dr. Fordyce.

The patient was a young man about twenty-one years of age who had a congenital heart lesion giving rise to persistent cyanosis. He had a well-marked acne of the face and trunk. In addition to the multiform lesions of acne, he had an enormous number of milium-like lesions over the chest, back, and face. They were larger, however, than the usual milium, and each had a central punctum similar to those seen in adenoma sebaceum. The lesions were unlike those seen in the usual type of the so-called adenoma sebaceum of the face, where they are more or less crimson in color due to the telangiectases. Here they were more or less

translucent and different from the dead-white of the ordinary milium lesion. The histological examination showed them to be made up of sebaceous glands much increased in number over their normal condition.

A Case of Unilateral Sweating. Presented by Dr. Dade.

Man, thirty years old. Trouble came on seven years ago without cause known to him. Right side of head, face, and neck always sweating, while left side is dry. The sweating is more pronounced after drinking a glass of beer or when he is cold. No subjective symptoms. Merely being a source of annoyance, for at times the hair is saturated and the sweat pours down over his collar, which is in an almost constant state of wilt, as may be seen at present.

In accordance with Dr. Lustgarten's suggestion, the patient would be put upon anti-syphilitic treatment.

Necrotizing Chilblain. (Previously shown.)

Presented by Dr. Whitehouse.

This case was presented at the previous meeting of the Society, and Dr. Whitehouse, instead of reporting on the case, asked the patient to come before the Society again and let the members see the improvement after a month's treatment, with iron and arsenic, and white precipitate locally. The lesions on the ear have all cleared up, which he thought would not be the case with the ordinary type of necrotic granuloma.

SECTION ON DERMATOLOGY.
NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, Oct. 29, 1907.

Dr. A. R. Robinson in the Chair.

Xanthoma Tuberosum Multiplex. Presented by Dr. W. S. Gottheil.

John S., 28; oysterman. Two years ago he first noticed the eruption, which began at the same time on the knees, elbows, hands, and buttocks. Since that time the individual lesions have been steadily getting larger, and new ones have appeared in their neighborhood. Has never consulted a physician about them, as they caused no inconvenience; and he comes for treatment now only because the growing tumors on the backs of his hands and wrists interfere with his work.

Examination: All the lesions, varying in size from a pin-point to a small marble, are typical pale yellow, yellowish-pink, and orange colored, prominent, sharply circumscribed xanthomata. Most of them are grouped in characteristic locations, but many of them are isolated or scattered over various parts of the body. Both knees are covered with

closely aggregated and sometimes confluent smaller tumors, and there are similar aggregations on the buttocks. Both elbows are similarly though less extensively affected; and here some of the individual tumors are quite large. On the backs of both hands are isolated and larger prominent tumor masses, for which he seeks relief. The skin of the sides of the chest shows a great number of very minute, but perfectly characteristic xanthomatous tumors, of the existence of which the patient is entirely unaware.

Treatment: An attempt is being made to destroy the larger individual tumors on the hands by means of the high tension spark applied by means of a carbon point electrode. A smaller one has apparently been destroyed by one application. On a larger one the effect was immediate bulla formation, resembling that from cauterization or freezing. The process is moderately painful, and in this case can be done without local anæsthesia. Speaker had obtained good results in another similar case by this method.

Method of making snow from liquid carbon dioxide for dermatological and surgical use. Exhibited by S. Dana Hubbard, M. D.

In presenting this drum of liquid carbonic gas, I am showing you something that is familiar to all, and something that can be obtained at short notice in almost every place in the whole world. In fact in the industries it is in almost universal use. It has been manufactured by one firm alone for twenty years, and with branch establishments in all of the prominent cities. In addition to the ease with which it may be obtained, it also has the additional advantage of being able to be kept on hand ready for use at any time. The use which I am going to make of this particular drum is quite novel—that is to some; but by others it has been used some months.

Permit me the reference—that in 1900 Dr. A. Campbell White, an associate of Trippler, presented liquid air for our use at the Vanderbilt Clinic. With the kind permission of Professor G. H Fox it was experimented with alongside of radium under the charge of Dr. S. G. Tracey, in various cases and with some degree of success; but after many years of experience we all had the same difficulty in obtaining it—in fact, to-day most of us do not know where to obtain it—and to use it, requires a more or less expensive apparatus—Dewar bulb and encasings, costing about seven to nine dollars, and at that is very fragile. "Air" also is very volatile. "Air" does its work splendidy, but with its costliness, the uncertainty of getting it at the desired moment, its volatility, and the danger of handling it makes the most ardent supporter of its use hesitate. I have been so often disappointed in obtaining "Air" that it was a case of obtaining it and then sending for my patients. Also there is a great element of danger in its making.

Comparatively "Air" is about -180° Centigrade, "Snow" -90° Centigrade. "Air" costs to-day $10.00 a gallon—$2.50 a liter—and you must furnish your own container. You must also send for it. It will not be delivered at the hour wanted.

Liquid carbonic gas, from which we make snow, costs $2.50 a drum of 20 gallons; it will be delivered at anytime anywhere, and the drum can be kept on hand and await desire of user. One drum will last indefinitely and many treatments can be made—a hundred or more.

Shortly after the introduction of "Air" and the various shortcomings becoming apparent, I began to look about for a substitute. I tried ethylated spirits—they failed, not freezing deep enough. Then the ammonia machines were investigated and they did not make cold sufficient for the purpose—then finally liquid carbonic was investigated.

I visited the sub-agency of the liquid carbonic company in West 107th Street, and there the foreman, at his noon hour, showed me how they could freeze meat—freezing quickly a piece of ham from a sandwich and throwing it upon the floor—breaking into many pieces. He repeated the process and I found that it froze quickly one-fourth to one-half inch deep. This seemed to me to solve the problem if it could be bridled.

I had a drum sent to the Vanderbilt Clinic and we then endeavored to apply it. The force of expulsion when the tank was opened was something terrific. We had made up various mechanical contrivances, some of which I show you; but our results were disappointing. The patients were frightened—the noise was terrifying—the vapor enveloping every one with considerable discomfort. The receptacle would sometimes freeze to the patient and we would have to await its thawing. This was at times ludicrous and at times disturbing, as we feared it would tear away from the struggling patient.

This was very unsatisfactory—it did not freeze sufficiently deep and our hopes again appeared to be fading away.

Naevi frozen by this method did not respond. They would be blistered and scab over, but on desquamating the color would soon return.

About this time Dr. George Thomas Jackson, our Chief of Clinic, learned of a method by Dr. W. A. Pusey of Chicago. He described it to us, but we did not seem to catch the knack of it and again we failed.

Lately, however, at the Dermatological Congress I had the good fortune to meet Dr. W. A. Pusey and informing him of my various misadventures, he very kindly volunteered to show me his method. With him I repaired to the liquid carbonic company, and we there made a ball of snow and brought it up to the Academy and used it on some of my cases.

The method I am going to show you this evening, is in general the method of Dr. Pusey. I desire that all credit be given to him; also at this time I desire to thank him for his great courtesy to me.

METHOD

Take a filled drum, place it on a shelf or table; *elevate* the bottom about eighteen or more inches. This assures snow being more quickly formed, for if there is any liquid in the tank, it will gravitate to the cock. Also snow made from the liquid is more moist and easier molded.

Fix the drum in place or have it held firmly. The opening cock is as a rule hard to turn—and when through using turn it off hard, to prevent leakage.

From the side of the head there is a brass hexagonal nut—unscrew this with a monkey-wrench—place on a shelf and be careful not to loose the composition washer within nut, when it is returned to tank.

Over this screw threaded outlet wind double-folded chamois skin folded as you see, and then either bandage in place or hold so by a toewl, wound around several times. When secure, open the cock at top of tank with the little socket wrench that accompanies the drum. Open full—soon there will be a bursting out of vapor and snow particles. Quickly turn off cock—turn off hard. Remove bandage or towel. Use great care in removing the chamois skin, as it is frozen hard, and if force is used it will tear.

Dr. Pusey makes a small bag of chamois two inches in diameter, tying it to tap. I find I tear the skin if I do and also it is hard to peel out the snow when it is frozen stiff. If the tank is new there will be moist snow which can be molded with the hands, using the chamois skin folded upon itself as a protection, or the fingers will be injured.

If the snow is very dry use little tubes made of test-tubing, or water gauge tubing (which is of heavier caliber), and pack it with a rod or pencil end.

If the chamois skin has been neatly applied and properly folded there will be a cigar shaped mold of snow, which can then be whittled with an ordinary knife blade down to the size desired. Always use a smaller piece of snow than the size of the growth to be frozen, as it freezes quite a little distance beyond its own area, and on exposed parts, like the face, this makes a red mark that is undesirable. Pick up the skin with the fingers and hold firmly so that the growth is itself elevated and the surrounding tissues are not attacked by the cold. Hold the snow with a piece of chamois skin folded upon itself or a towel folded several times, or with a pair of dressing forceps, exerting pressure of snow onto growth. *Time* the exposure, for this, in a measure, determines the depth of the freezing. Five seconds will remove the top cellular layer. Ten seconds will attack the papillary layer—useful for removing tattoo marks —and for deeper growths 20 to 30 to 40 or more seconds. In some cases it is well to freeze the tissue solid; let it thaw out and repeat the process. This latter is very good in hypertrophied conditions as callosities, tattoo marks, pigmented moles, naevi, warts, etc.

Permit me to caution you that in the pigmented moles be very cautious about informing the friends of the permanence of the removal; for in one of my cases, a lad of thirteen years, a black pigmented mole removed with liquid air from the chin with apparently a perfect result, returned as intense as formerly in three years. Large coarse hairs are at times very rebellious. In certain races bear in mind the formation of keloids. I have not seen any appear as yet, but from the use of acids they have been caused several times at the clinic. Regarding the pain caused by the operation, I have had my arm frozen by the snow and it was painless; there was a redness, followed by a wheal, resembling an urticarial lesion, and in time swelling, with the formation of a vesicle which soon shriveled and scabbed and desquamated, leaving a snow white scar level with the surface. In certain areas, about the nose, eyes, it is quite painful. Once in operating on the temple I had to discontinue on account of the severity of the pain; but here I think I was irritating a sensitive nerve. However, I generally tell patients it does not hurt much, and after the operation is over ask them if it pained them more than they had expected. Some are hyperæsthetic and others not so much so.

The scar in both "Air" and "Snow" freezing is about the same. It appears to be a cellular affair—non-contracting—does not sink below skin surface and is snow white.

DISCUSSION.

Dr. Dade: Seven years ago last April, on a case of the fixed form of erythematous lupus, which had resisted every method applied to it by us at the Vanderbilt clinic, I first used liquid air. The areas treated then have remained cured to this day, and I have shown the case several times. Since then erythematous lupus of the fixed type has been treated with liquid air at the clinic to the exclusion of everything else, except for experimental purposes, for nothing heretofore had given us anything ilke the results it gives, and even it in some long-standing cases has been but partially successful. Since this first case the use of liquid air at the Vanderbilt clinic has been almost exclusively in my hands, principally in the treatment of angiomata, but I have not yet published my cases. as I am waiting to complete some experiments on rabbits' ears, undertaken to study the action on the tissues of liquid air before giving out anything on the subject. Radium, as Dr. Hubbard says, was persistently used side by side with liquid air, and long ago given up as vastly inadequate in comparison. Up to September last, when Dr. Pusey, at the meeting of the Dermatological Congress, showed Dr. Hubbard and me his method of using carbon dioxide, this agent had given us no results whatever. Since then Dr. Hubbard has been using it systematically after Dr. Pusey's method. As yet not enough has been done to make any comparison with Dr. Pusey's excellent results, or to show its merits over liquid air; certainly the cases shown to-night, especially of pigmented hairy nævi to which five applications of carbon dioxide have been made, would have been removed before this by liquid air, if we can judge from what it has done in the past in similar cases. The patients' testimony at the clinic on whom both the agents have been used would seem to be of some value, for they one and all say the liquid air is much surer and quicker in its action; at any rate they seem to prefer it. There

are two advantages as to its application that the carbon dioxide seems to me to have that Dr. Hubbard does not mention—first, its adaptability to very small nævi, for here the column of snow can be made any size; and second, the ability to so fashion the piece of snow as to exactly conform to the outline of the lesion to which it is to be applied. There is no difficulty now in obtaining liquid air. The Westinghouse Lamp Co., 513 W. 23d Street, furnishes it regularly, and the New England Refrigerating Co., Norwich, Conn., will send it anywhere desired.

CHICAGO DERMATOLOGICAL SOCIETY.

Meeting of November 29, 1907.

Dr. R. W. Bishop, Chairman, *Pro Tem.*

Case of Congenital Syphilis. Presented by Dr. W. A. Quinn.

The child, 10 months old, was well nourished and according to the mother's statement had always been healthy. One week ago a few "spots" appeared on the forehead. At present there is a group of six or eight papules about each eye-brow. The mother gives a history of having had one still-birth, one miscarriage, and one child, who when four years old showed a skin eruption which cleared up under mercurial inunctions.

Lupus Erythematosus, Unusual Case of. Presented by Dr. Zeisler.

The patient, a man of forty-eight, presented an interesting facial dermatosis, which had existed for the past fifteen years, recurring at irregular intervals and responding always to treatment by X-rays. There were several superficial ulcerations; one of these had involved the right lower eye-lid and caused an ectropion; another was situated on the corner of the right ala nasi, and one was present in the center of the right cheek. There were also several isolated circumscribed dry lesions covered with loosely adhering grayish crusts and scales. Dr. Zeisler excluded syphilis, rodent ulcer, and blastomycosis, and presented the case as an unusual form of lupus erythematosus.

Case of Blastomycosis. Presented by Dr. W. A. Pusey.

The patient was a man aged 63. The disease appeared six months ago; the lesion involved the inner two-thirds of the back of the hand extending from the base of the index finger to the wrist and from the base of the thumb over two-thirds of the breadth of the hand. The patient was a carpenter who lived under good hygienic conditions in a town of 20,000 inhabitants.

Case of Psoriasis. Presented by Dr. Zeisler.

The patient demonstrated presented features rather uncommon in psoriasis. He was a pianist by occupation, and the eruption was present in a severe form on all the fingers, and on the palmar surfaces of both

hands. The picture in the latter location resembled strongly a squamous popular syphilide. There were a few small patches on the scalp, but the body was almost completely free of lesions. The practical restriction of the eruption to the hands, which were severely affected, was interesting and suggested his occupation as a strongly predisposing factor.

Case of Ichthyosis. Presented by Dr. QUINN.

The usual fish-scale appearance was presented by the patient, a five year old boy with blond hair. His maternal grandfather is reported to have had a similar skin affection.

Case of Universal Psoriasis. Presented by Dr. WM. A. PUSEY.

Man, aged 50, with almost universal psoriasis. The face, palms, and soles were entirely involved and but for occasional small islands of healthy skin, the eruption was universal.

Case for Diagnosis. Presented by Dr. W. A. PUSEY.

Man, aged 55, with a peculiar eruption which had existed since childhood. The eruption consisted of macules, some of them very slightly elevated, from 1-16 to $\frac{1}{8}$ of an inch in diameter. They were of pinkish to dark red color and disappeared under strong pressure. In a few of them, particularly on the arms and legs where the color was deepest, slight pigmentation was present, shown upon pressing out the blood. The lesions were discrete but were abundant upon the sides of the trunk and the inner aspect of the arms, thighs and legs. A very sparse eruption existed upon the anterior surface of the trunk; very little upon the back and extensor surfaces of the limbs. There were none on the hands, face or neck. The eruption was distinctly symmetrical. It had existed since childhood and has never given the patient any discomfort.

In early manhood the patient suffered occasionally from urticaria, but this was never severe and he never had long continued intractable urticaria. There were no wheals present nor the history of a recent occurrence of wheals, but factitious wheals could be excited by rubbing any point upon the skin, not more noticeably at the sites of the lesions than upon other parts of the body. The case was first seen by Dr. Pusey more than a year ago and has remained unchanged during the interval. The patient, a physician, is positive that the eruption has not changed for many years.

The clinical picture was regarded as unique; it was distinctly not that of urticaria pigmentosa, although in the opinion of those present as far as it was expressed, the condition was allied to urticaria pigmentosa.

Case of Disseminated Chronic Lupus Erythematosus in Large Patches. Presented by Dr. W. A. PUSEY.

Man, aged 60, German, in vigorous health, with erythematosus lupus,

existant since early manhood. The disease occurred in patches, varying from coin size to a foot or more in diameter. The scalp and half of the face or neck. The eruption was distinctly symmetrical. It had existed since childhood and has never given the patient any discomfort.
patches with a diameter of 8 to 10 inches; in the left thigh there was a patch covering almost the entire extensor surface.

REVIEW OF DERMATOLOGY AND SYPHILIS.

Under the Charge of A. D. Mewborn, M. D.

BACTERIOLOGY AND PARASITOLOGY

Sporotrichosis

A Digest Review By A. D. Mewborn, M. D.

Schenk: On refractory subcutaneous abscesses caused by a fungus possibly related to the sporotricha. *Johns Hop. Hosp. Bull.*, 1898, p. 286.

Brayton: Chronic Abscesses. *Ind. Med. Jour.*, 1899, p. 272.

Hectoen and Perkins: Refractory subcutaneous abscesses caused by the Sporothrix Schenkii, a new pathogenic fungus. *Jour. Exper. Med.*, 1900, p. 77.

De Beurmann and Ramond: Absces sous-cutanés multiple d'origine mycosique. *Ann. Derm. e Syph.*, 1903, p. 678.

Matruchot and Ramond: Un type nouveau de champignon pathogene chez l'homme. *Compt. Ren. Soc. Bio.*, 1905, p. 379.

De Beurmann and Gougerot: Les sporotrichose hypodermiques. *Ann. Derm. Syph.*, 1906, p. 837, p. 914, p. 993.

Dor: "La Sporotrichose." *La Press. Med.*, 1906, p. 234.

Monier-Vinard: Formes cliniques et diagnostic de la sporotrichose. *La Presse Med.*, 1907, p. 426.

Gaucher: La Sporotrichose. *Gazette des Hop.*, 1907, p. 795.

Rubens-Duval and Fage: Un nouveau cas de sporotrichose gommeuse cutanée et sous-cutanée. *Bull. Soc. Med. d. Hop.*, 1907, p. 380.

Lauby and Esmein: Un cas de sporotrichose sous-cutanée et cutanée. *Bull. Soc. Med. d. Hop.*, 1907, p. 386.

De Beurmann and Gougerot: Sporotrichoses. *La Presse Med.*, 1907, p. 481.

De Beurmann and Gougerot: Sporotrichose tuberculoides. *Ann. Derm. et Syph.*, 1907, p. 497, p. 603, p. 655.

Demoulin and Rubens-Duval: Nouveau cas de sporotrichose. *Gaz. des Hopitaux*, 1907, p. 1098.

The first two cases of this dermatomycosis were observed in America by Schenck in 1898, and by Hectoen and Perkins in 1900. The histories

of these two cases were similar in that the infection started from a wound of the finger which was followed by multiple subcutaneous abscesses running up the arm along the lymphatics. These abscesses were not painful, some opened spontaneously and others were opened surgically and found to contain an aqueous or gelatinous fluid. From this was isolated the sporothrix Schenkii.

The case described by Brayton in 1899 occurred in a healthy young florist who punctured a finger with a wire while making a bouquet. A succession of chronic abscesses with gelatinous contents appeared, extending during a period of two months from finger to elbow, much scarring being left behind. Case not examined bacteriologically. The three cases have much in common, in all a succession of small abscesses developed consequent upon injury by similar means. Schenk's case the scratch of skin of finger by a nail, in Perkin's case the blow upon the finger by a nail, in Brayton's case the puncture of finger by a wire. All three cases marked by the refractory nature of the subcutaneous abscesses.

In France the first case was described by De Beurmann and Ramond (1903), and the parasite which was isolated by culture from the lesions of their patient was identified by Matruchot, who proposed the name of Sporotrichium Beurmannii. In 1906, De Beurmann and Gougerot, having observed three new cases, published a very important study of the cultural and morphological peculiarities of this organism. De Beurmann places the cases described by Schenk, Hectoen and Perkins, as well as one described by Brayton, in the same category as caused by a fungus similar to his sporotrichium. Since De Beurmann's paper cases have been described by Monier-Vinard, Dor, Gaucher, Rubens-Duval and Fage, Laubyand Esmein bringing up the total to thirteen cases with positive determination of the parasite.

Symptomatology. The port of infection is most often through a wound (punctured, incised or contused), a trace of which may be found when the first manifestation of the disease appears. At other times the method of acquiring the disease remains a mystery. De Beurmann found the sporothrix in the lacunar crypts of the tonsil in one of his cases. He succeeded in reproducing the lesions of disseminated sporotrichosis in a new-born guinea-pig by feeding it upon milk mixed with cultures of the sporothrix. The manifestation may be dermic, hypodermic, rarely epidermic, exceptionally visceral. Infection of he subcutaneous tissue terminates in the formation of a true cold abscess which may attain size enough to hold 500 c. c. of pus, having subjective and evolutive character of a tubercular abscess differing principally in greater numbers. Usually the subcutaneous lesions develop insidiously along the limb in the form of painless nodules from the size of a pea to a small mandarin, seldom less than five in number. To palpation they are firm and attached to subject aponeurosis. At the end of two or three months they soften, the skin reddens, becomes violaceous and finally a viscous, homogenous, grey-yellow pus escapes through a small

orifice. This orifice may become a large fistulous opening with swollen edges and new infiltrations. In the end this suppuration diminishes and a violet cicatrix or keloidal scar remains. Incision by the bistuory does not hasten the curative process, as new nodules form in the line of incision. Such an evolution may be looked upon as the most favorable, as sometimes the ulcerating crust covering a fistulous opening may leave a patch exactly simulating a verrucous tuberculosis. In the majority of cases in spite of the extreme dissemination of the lesions and the fact that lymphatic chains are affected the lymphatic glands often remain unaffected; unless with an open sinus secondary infection takes place.

The disease may develop in the skin by an extension upward from a subcutaneous nodule or it may develop primitively in the dermis. This form is described in a patient of Monier-Vinard who developed upon the face a large number of rounded nodules the size of a franc piece distinctly elevated of the color of barley sugar (*sucre d'orge*). The surface at first smooth and humid became after two or three months rough and covered with a yellowish coating. The cicatrices remaining took on the aspect of those left by a lupic tubercle.

The epidermic form arises secondarily to the evacuation of a hypodermic abscess by multiple surface inoculations. Opaline vesicles form around the central opening resembling somewhat a patch of trichophytosis. The sporotrichium was found by Monier-Vinard in the expectoration of a patient who was at the same time affected with a pulmonary tuberculosis. This was probably a visceral form in a case of mixed infection such as has been found in actinomycosis.

Cultures. The best culture medium is that of Sabouraud recommended for studying the trichophytons. Streak cultures are made upon this medium of the pus taken from the suspected lesions. The usual precautions are taken to avoid contaminations. Avoid the use of rubber caps over the cotton plugs. Keep cultures preferably at room temperature. On the sixth to eighth day small round white colonies appear along the line of streak. The cultures are very adherent to the medium, spread, become elevated and wrinkled, and take on a dark brown color from the formation of spores. In bouillon the growth may form a veil or a flocculent down without the medium becoming cloudy. In the hanging drop the parasite appears as a fine ramified mycelium, with partitions at long intervals. Short sterigmates hold oval or ovate spores. The terminal filament may be capped by a bouquet of spores to the number of seven or nine.

Animal Inoculations. De Beurmann succeeded in inoculating newborn guinea-pigs, but with inferior results to that obtained by inoculating the rat's foot. By the latter method the author succeeded in producing a sporotrichosic gumma with hypodermic metastasis.

Differential Diagnosis. The large hypodermic sporotrichosic abscess resembles very much the cold abscess from bone tuberculosis. The

absence of painful points over bone or joints and the multiplicity of lesions are useful in forming an opinion. The disseminated nodular or lymphangitic form may be confounded with sub-cutaneous fibro-lipomata, generalized sarcomatosis, cysticerous or staphylococcic abscesses, syphilitic gummata, tuberculosis or the subcutaneous sacoid of Darier-Roussy. The dermic form may simulate exactly certain lupiform syphilides. Dermic sporotrichosis may also resemble certain atypical forms of cutaneous tuberculosis. In fact, the existence of syphilis or tuberculosis cannot be used as an argument against sporotrichosis since the two affections may coexist. It is upon the laboratory and especially the test of cultures upon which greatest reliance must be placed.

The histological picture too closely resembles tubercular or syphilitic lesions to be reliable.

The last three papers of De Beurmann and Gougerot are particularly devoted to the histological study of the sporotrichosis lesions. To resume, these authors found that sporotrichosis is a chronic nodular suppurative affection. Certain chronic lesions due to cocci have the same three zone arrangement. The same mixture of inflammatory reactions,—basophile, tuberculoid, and suppurative. The same evolution towards the polynuclear and macrophagic abscess. It is then more the chonic coccic suppurations to which it must be compared than to the syphilitic or tubercular processes. It only partially resembles the latter two affections. It resembles tubercle by its middle zone and syphilis by its middle and specially by its outer zone of reaction.

The nodular infiltration, the giant cell, the follicular suppuration are not specific to any one parasite, but are general reactions set in motion by different causes having a mode of action identical in their force and duration.

There is not an anatomic specificity but a specificity of the causal parasite. If different causal agents have the effect of producing the same reactions the lesions will be similar. The sporotrichium and the tubercle bacillus may cause almost identical lupus like follicles. If the mode of action of the same germ varies it may produce different lesions, that is, the sporotrichium may determine lesions of a syphiloid, tuberculoid or ecthymatiform character.

Prognosis and Treatment. The prognosis is rendered clear by the extreme efficacy of the iodide treatment. The resort to surgical means is contraindicated except in the case of voluminous pus collections, on account of the extreme liability of infecting the borders of the incision by new infiltrations. The multiplicity of lesions renders complete ablation dufficult. Iodide of potash is to be given by mouth in doses of 2 to 5 grammes per day.

The local application of compresses saturated with iodide of potash solution to open lesions gives remarkably favorable results. In almost every case a complete cure ought to be obtained in from two to four months.

BOOK REVIEWS

Syphilis in its Medical, Medico-Legal, and Sociological Aspects, by A. Ravogli, M. D., Professor of Dermatology and Syphilology in the Medical College of Ohio, Medical Department of Cincinnati University, Dermatologist to City Hospital of Cincinnati, etc. The Grafton Press, New York.

Syphilis, in respect to its effects upon the productivity, the vitality and physical progress of the race, must be regarded as a greater danger to society than to the individual. The danger of syphilis to the individual is not measured by its immediate effects upon the health or life, but by its capacity of inaugurating changes in the organs essential to life, which weaken their capacity of resistance and render them an easy prey to other processes of disease at a more or less remote period. While recent acquisitions to our knowledge of the pathology of syphilis have amplified our conception of its individual danger—particularly in its late or terminal stages—this newer knowledge has served to especially emphasize its significance as a social danger.

It was doubtless an appreciation of this fact that led the author of the work before us to make a departure from the method usually followed in treatises on syphilis and plan his work on a more comprehensive scale. Instead of confining himself to an exposition of the medical aspects of syphilis, he has devoted a large portion of his book to the consideration of its medico-legal and sociological aspects.

After referring in his preface to the profound impression made by syphilis on the nervous system and the "alterations in the psychical sphere" resulting therefrom, he states: "It is, therefore, easily understood that all these questions pertaining to the syphilitic alterations in the man who becomes infected, and to all his relations to his wife, to his family, and to society, form a vast and important sociological study which we shall carefully consider in all its details."

In Part I, which relates to the medical aspects of syphilis, the initial chapter is devoted to a historical account of "The Search for the Causal Agent," leading through the investigations of Klebs, Lustgarten, Van Niessen, Jullien, Joseph and Piorkowski, and other claimants, and culminating in the discovery of Schaudinn and Hoffmann in 1905. The spirochæta pallida is unqualifiedly accepted by the author as the germ producing syphilis. It may be said that while the rigorous conditions demanded by modern science have not been complied with in the case of the spirochete, especially its successful culture outside the human body, yet its more or less constant identification in the blood and lesions of syphilitics affords strong presumptive evidence of its causal relation to syphilis.

This part of the work offers nothing which requires special comment or criticism. The description of the pathology and symptomatology of syphilis conforms in the main to what is usually found in text books on syphilis designed for the use of the student and general practitioner. The author's observations on treatment, its character and duration, the choice of methods, etc., reflect the views generally held by modern text book authorities.

Comment may be made upon the relative space and importance assigned to the natural divisions of the subject matter: Thus, less than 25 pages are devoted to "Syphilitic Affections of the Skin and Mucous Membranes," while the chapter on "Syphilis of the Nervous System" occupies 30 pages. Less space is given to the chapter on "Constitutional Syphilis" than to that on "Transmission of Syphilis to the Offspring." The greater relative importance given to nerve

syphilis and pseudo-syphilis may be explained on the assumption that the author wishes to lay the groundwork for his thesis on the sociological significance of the disease by emphasizing its dystrophic and degenerative changes in the offspring, and its no less pronounced alterations in the sphere of the nervous system.

In Part II the medico-legal and sociological aspects of syphilis are considered under the following headings: Syphilis and Marriage, Syphilis in Relation to Degeneracy, Syphilis and the Public Health, and the Regulation of Prostitution in the Prophylaxis of Syphilis. The important relations of syphilis with marriage are duly recognized, and the conditions of admissibility of a syphilitic man to marriage long ago formulated by Fournier are insisted upon in a general way. Dr. Ravogli's recipe for safeguarding marriage from syphilis is the enactment of a State law requiring of every candidate for marriage a medical certificate from an expert appointed by the Probate Court. Certain objections of Morrow, whom he quotes at length, based upon the difficulties in the practical application of such a law, he dismisses as a mere "bugaboo." "The objection that many aspiring to marriage will go to another State where such a law is not in force may be true, but we do not care. Anyone who has done anything wrong and wants to evade the law may do so if he chooses; he will suffer the consequences." Unfortunately, it is not the evader of the law, but his innocent wife and children who will suffer the consequences.

Syphilis as a cause for divorce, the medical secret, professional ethics, and syphilitic patients are considered in this connection.

The chapter on syphilis in relation to degeneracy, the decadence of populations, as a predisposing cause of crime, of prostitution, and of sexual perversion, reflects perhaps more than any other part of the book the personal views of the author. Many of these views are valuable and suggestive, while others rest upon a slender support of facts and appear quite indefensible.

The contention is made that syphilis is not a disease of antiquity, but first made its appearance in the Old World with the return of Columbus and his followers, and "spreading epidemically with no treatment at all, or with an inadequate one, was transmitted to the second and to the third generation." We cannot follow Dr. Ravogli in his remarkable historical disquisition upon the influence of syphilis as a factor in the decadence of the sixteenth century. He concludes: "From all that which we have considered in this chapter, we can state that a new and unknown disease, syphilis, had made its appearance among the people. The decadence began to appear nearly fifty years after this disease had spread in an epidemic form among the individuals of the social classes. By this time we have two generations: one which had acquired syphilis, and one which had inherited syphilis. If syphilis at our age often affects the nervous system and is capable of inducing psychoses, at that time it could in the same way produce mental disorders. When syphilis has acted in the individuals as an hereditary taint on the descendants of the first and second generations, then it is capable of inducing forms of psychoses of a peculiar kind which give us the right to consider it the reason for the decadence of the sixteenth century." This reasoning and conclusion will hardly meet with general acceptance. We can no more ascribe "the murders, the carnages, and the pillages" of the sixteenth century to syphilitic psychoses, than we can, as the author asserts, "attribute a good part of the carnivals of blood, of pillages, and of persecutions which are at present enacted in Russia to the excitement of the psychical faculties due to syphilitic disturbances of the brain."

Quite extended consideration is given to syphilis as a predisposing cause of crime. The author asserts that a strange relation exists between syphilis, crime and prostitution. The statement that "Prostitution which frequently cannot be explained or excused by poverty or by special accidents is to be attributed to hereditary syphilis," is open to serious question.

Under "Syphilis and Public Health" are considered Syphilis and Life Insurance, Public Prophylaxis, Causes of Prostitution, Sanitary Consequences, Prevention and Coercion, etc.

In the final chapter on the Regulation of Prostitution in the Public Prophylaxis of Syphilis, Dr. Ravogli proclaims himself a strong advocate of regulation of prostitution by law, but insists that the "application of this law must be left in the hands of the health department of the communities and of the municipalities."

The general appearance and make-up of the book are most creditable to the publishers. The paper is good and the type clear and legible. The illustrative plates, of which there are 16, many of them containing two or more figures, are of unusual artistic excellence.

P. A. M.

Jahresbericht uber die Leistungen und Fortschritte auf dem Gebiete der Erkrankungen des Urogenital-Apparates.

By Prof. A. Kollmann and Dr. Jacoby. Published by S. Karger, Berlin, 1907.

The second volume of this work, covering the urological literature of 1906, not only continues the admirably high standard of accuracy and completeness set by the first, but even surpasses it.

We have verified a number of quotations and find them most intelligently abstracted and accurately set down. The slip of a letter here and there is pardonable in translations from a foreign tongue, and sometimes joyous, as in the citation from Dr. Boston-Bangs.

In each section the number of pages has been increased; this increase being greatest of the chapter on kidney and ureter, which has been lengthened by twenty-two pages, and that on diseases of the female, lengthened twenty-three pages.

Moreover, a large chapter has been added on the urinary diseases of domestic animals, and a much more important one reviewing all the books published on urology during the year.

If the work needs a final word of praise, let it be this—the preponderance of German references is much diminished in this present work; counting the authorities cited in three sections taken at random, we find 87 German references, 73 French, 28 American, 12 Italian, 11 English, and 21 of other nationalities. In some clinical sections the French citations actually outnumber the German ones: so catholic a taste merits the greatest praise.

This volume like its predecessor is one which no urologist can afford to be without.

Atlas der Venerischen Affectionen der Portio Vaginalis Uteri und der Vagina. von Dr. Moritz Oppenheim. Published by Franz Deuticke, Leipzig und Wein, 1908.

This Atlas presents both admirably and adequately the venereal lesions of the portio vaginalis of the cervix uteri and of the vagina.

The plates showing chancroids, chancres, mucous papules, and gummata are both numerous and interesting. Condylomata acuminata are included in the lesions pictured; but curiously enough only one gonorrheal lesion is shown, and that a relatively unusual condition of gonorrheal macules of the cervix.

We foresee that these plates will figure in many a future volume on venereal disease and on gyneçology.

Diseases of the Genito-Urinary Organs and the Kidney. By Robert H. Greene, M. D., Professor of Genito-Urinary Surgery at the Fordham University, New York; and Harlow Brooks, M. D., Assistant Professor of Pathology, University and Bellevue Hospital Medical School. Octavo of 536 pages, profusely

illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, $5.00 net; half morocco, $6.50 net.

A new text-book must fill a new need; for such a thing as a text-book is rarely a long felt want.

This book purports to fill the needs of urology in the largest sense. It begins with a General examination of the patients, Endoscopy, Cystoscopy, Catheterization of the ureters, Care of urethral instruments, Operative preparation, Urine analysis and continues from the Diseases of the kidney, both medical and surgical, to those of the lower urinary organs and of the genital organs in the male, but devoting to the last only 37 out of 512 pages.

The effort to make this book a strictly urological one is thus manifest and is well carried out.

The illustrations are numerous, many of them are original, and some, especially the pathological and operative ones, extremely interesting.

The general appearance of the book is excellent; and here, alas, endeth our praise.

The text shows an unfortunate vagueness in its most important and practical details; indeed, one might characterize some of the statements as worse than vague; let us note a few examples: "Internal urethrotomy is to be performed only when the stricture is at the bulbo-membraneous junction." "In acute anterior urethritis in those cases in which most of the effects of the disease are evident in the anterior urethra, some advocate the passage of the sound into this portion of the urethra; the discharge diminishing very considerably at the end of about the fifth week." If this sentence means anything, it points the moral already insisted upon by Hudibras:

"Ah me, the perils that environ
The man that meddles with cold iron."

The following quotations, taken from a section on nephrectomy, illustrate another unfortunate feature of this book, viz., the fact that where the authors themselves had the right idea in their minds they fail signally to express it in such a way as to impress the student with the importance of the detail as well as with the technic.

"Before undertaking nephrotomy, it is well to ascertain positively that the other kidney is in a healthy condition; this is often done by ureter catheterization or by examination of the organ and through exploratory incision" . . . "In some cases it is so difficult to get at the pedicle that it may be advisable to leave the clamps in place in the wound for twenty-four hours." . . . "In saturing the wound after nephrectomy, whenever practical three sets of satures should be employed a deep set for the deep muscles, a middle set, and a superficial set."

In discussing tuberculosis of the kidney, the authors state that in descending infection (the overwhelming frequency of which they do not appear to concede), the lesions "pursue a relatively innocent course and are not commonly diagnosed unless the necrosis of the tissue becomes sufficiently extensive to cause drainage into the pelvis or marked febrile symptoms."

The following sentences illustrate another form of vagueness. "Gomerol, a substance somewhat resembling guaiacol—" "Undoubtedly there is pathologic evidence to support the views of many who have written concerning the diseased conditions of the seminal vesicles" . . . "Early in the history of their catheter life patients may be able to use the catheter three times a week." . . . 'Of the newer remedies, probably albargin, in the strength of 1-5000; will give good results."

Such errors as this, and they are extremely numerous throughout this work, must neutralize the advantages offered by its intelligent general arrangement and its excellent illustrations.

OBITUARY

ROBERT WILLIAM TAYLOR

Robert William Taylor, son of Robert and Phebe Taylor, was born at Coventry, England, August 11, 1842.

His father was a graduate of Oxford University, and possessed of considerable means. Through the dishonesty of an associate he lost the greater part of his fortune, and came to this country in 1850, bringing with him his wife and only child, Robert W. He died in this city not long after. The widow married William Curtis and removed to Newark, N. J. Mr Curtis soon died and young Robert was left in the care of his mother. He received a good English and classical education up to his fourteenth year, when his ambition led him to seek a business opening with a view to self-support, rather than to be a burden to his widowed mother. This was a matter of choice rather than necessity, as Mrs. Curtis was in comfortable circumstances Robert's first engagement was as a drug clerk, but his ability and diligence was such that before reaching his twenty-first year he was in virtual charge of one of the most important drug stores in this city.

Later, believing that pharmacy was not a broad enough field, he entered the office of the late Professor Willard Parker as a student of Medicine, and was graduated from the College of Physicians and Surgeons (Columbia University), in 1868. In 1863 he married Jane Webb, by whom he had two daughters and one son, the elder daughter alone surviving him. His wife died in 1881. In 1884 he again married, his second wife dying in 1899.

During the first few years after his graduation he devoted much time to the study of the French and German languages, and later acquired a good working knowledge of Italian.

Taylor at first devoted himself to general practice, locating his office in Amity Street, whence he removed successively to East 12th Street, to West 21st Street, and finally to West 48th Street, where he died January 4, 1908.

Early in his professional career he made the acquaintance of the late Professor Freeman J. Bumstead, whose confidence he enjoyed until the latter's premature decease. Both were men of the strictest integrity, and it is therefore not surprising that the affection between them was profound and lasting, as the present writer, intimately acquainted with both men, can personally testify.

Although Bumstead was no mean scholar, Taylor was much the better

DR. R. W. TAYLOR.
(Courtesy of *The New York Medical Journal.*)

and a more thorough student, and soon acquired a knowledge of the literature of cutaneous and genito-urinary diseases that was phenomenal. His memory, too, of the details of cases seen many years before, and his ready reference to the works and writing of others, was a constant surprise to his associates.

Taylor's contributions to the periodical literature were frequent and of a quality that very early gained an international recognition. In fact, many of his monographs were superior to anything that elsewhere appeared on the same topics. His first more ambitious work was in collaboration with Bumstead in the well-known volume that bears their joint names. The major part of this undertaking fell on the junior writer. Since then other volumes on cognate topics have appeared, fully bearing out the author's reputation for thoroughness and fidelity to truth.

As a practitioner Taylor was careful and skillful. His early gained knowledge of pharmacy here being of immense service to him. As a genito-urinary operator he was conservative. He never went to the extremes advocated by the late Dr. F. N Otis, nor did he possess the delicate operative skill of the Nestor of genito-urinary surgery (Dr. J. W. S. Gouley), whom we still have with us.

Taylor was a successful teacher, holding a Professorship at the College of Physicians and Surgeons from 1891 to 1904.

I would like to close by a few words of personal testimony as to Taylor's character as a man, but find none that more eloquently express my own feelings than the following received by me a few days after his death:

"What a useful man he was, and how genial and straightforward—how free from sham and pretense. To have known such a man is a delight and a memory to be treasured. We are none of us young, but the great thing to be desired, it seems to me, is to be useful as long as one stays here."

H. G. P.

PROFESSOR OSCAR LASSAR

It is with deep regret that we record the death of Professor Oscar Lassar on December 21, 1907, as the result of an automobile accident about ten days previously. The condition of Dr. Lassar was not considered very serious at the time of the accident, but several days later sepsis developed, to which he succumbed.

Prof. Lassar enjoyed an international reputation among medical men, not only on account of his numerous contributions to dermatological literature and valuable additions to the therapeutics of skin diseases, but also from his diverse interests and activities in other branches of medicine.

Dr. Lassar was born in Hamburg, January 11, 1849. His early education was received at the gymnasium; from 1870 to 1871 he served

in the Franco-Prussian War. Resuming his studies, he received his degree in 1872. He worked in the laboratories of the physiological chemists Hoppe-Seyler and Salkowsky, and studied with Virchow and Traube; he then became the assistant of the physiologist George Meissner in Gottingen; from here he went to Breslau, where he worked with Cohnheim from 1875-1878. It was his original intention to adopt internal medicine as his special line of work, but shortly after settling in Berlin in 1878 he became assistant to George Lewin in the Dermatological Division at the Charité. In 1880 he was made Privatdocent at the University, and a few years later founded his Institute and Clinic at 19 Karlstrasse, where he gave instruction to students and practitioners of Dermatology. This Clinic was one of the largest in Germany, and was annually visited by from 10,000 to 15,000 patients. Dr. Lassor's success in handling patients was largely due to his genial personality, tact, and the interest the patients themselves aroused outside of their diseases, for he considered the human side of medicine quite as important as its scientific or therapeutic side. He was a good lecturer and knew how to interest young physicians and students and to awaken in them a desire and love for the work. He considered Dermatology the one field in medicine best suited for research, and he had high ideals for, in his opinion, the dermatologist must be a good histologist, physiologist and therapist; in fact, must leave no realm unexplored in order to advance the science.

He was a pioneer in cutaneous therapy, and was anxious to disseminate his knowledge that all practitioners might benefit from his experiences. To this end, he lectured and attended society meetings and congresses, where he presented cases, moulages, pictures, etc. He spared neither pains nor expense in his demonstrations.

He likewise had a happy genius for organizing. In 1886 he was an active member in the organization of the Berliner Dermatologische Gesellschaft; in 1890 he was Secretary-General of the International Medical Congress held in Berlin. About fourteen years ago he founded the Dermatologische Zeitschrift. He participated in the organization of the Deutsche Naturforscherversammlung, and was one of the organizers of the Gesellschaft für Sociale Medicin as well as the Deutsche Gesellschaft für Volksbäder. He took a profound interest in all matters pertaining to hygiene and popularized bathing among the poor. In the midst of all his professional demands, he did not neglect the social side of life, and found relaxation in sports and in writing stories for children.

The writer of this sketch was his pupil about twenty years ago, and recalls with much pleasure the stimulating influence and many acts of kindness of this genial and versatile Professor of Dermatology.

J. A. F.

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III. Modes of Infection.

The Evolution of Syphilis.

IV. Primary Syphilis.

V. Constitutional Syphilis.
- Affections of the skin.
- The skin appendages.
- Other tissues and organs.
- The mouth and alimentary tract.
- The respiratory tract.
- The heart and blood vessels.
- The liver, spleen and kidneys.
- The male genito-urinary organs.
- The female genito-urinary organs.
- The bones and joints.
- The muscles and bursæ.

VI. Syphilis of the Nervous System.
- The brain.
- The spinal cord.
- General syphilitic affections of the nervous system.
- Locomotor ataxia.
- General Paralysis.
- Syphilis of the organs of the special senses.

VII. The Nature of Syphilis as Influenced by Other Conditions.
- Causes of Malignancy.
- Mixed infection.
- Alcohol.
- Tobacco.
- Other disease causes.
- Individual dangers as to morbidity and mortality.

VIII. Parasyphilitic Affections.

IX. Syphilis in its Effect Upon Other Diseases.

X. The Treatment of Syphilis.
- Internal treatment.
- Injection treatment.
- Inunctions.
- Fumigation.
- Physiological action of mercury.
- Poisoning by mercury.
- Iodides.
- Individual prophylaxis.

XI. The Transmission of Syphilis to the Offspring.
- Direct transmission.
- Germinative infection.
- By conception.
- Maternal heredity.
- Syphilitic immunity.
- Symptoms and consequences of congenital and hereditary syphilis.
- General treatment of congenital syphilis.
- Constitutional treatment of congenital syphilis.
- Prophylaxis.
- Retarded hereditary syphilis.
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PART II.

THE MEDICO-LEGAL AND SOCIOLOGICAL ASPECTS.

I. Syphilis and Marriage.
- Syphilis as an impediment to marriage.
- Syphilis as cause of divorce.
- The medical secret.
- Professional ethics and syphilitic patients.

II. Syphilis in Relation to Degeneracy.
- Degeneracy.
- Physical signs of degeneracy.
- Syphilis and the decadence of population.
- Syphilis as a predisposing cause of crime.
- Syphilis and sexual perversion.

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